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1986-1987 Source Book of Health Insurance Data

Prepared by the
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Health Insurance Association of America
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Foreword

The 1986-1987 edition of the *Source Book of Health Insurance Data* is a statistical report of the private health insurance business in the United States. It is currently published biennially (with selective updates in the interim years) by the Public Relations Division of the Health Insurance Association of America on behalf of companies that provide health insurance to the American public.

This edition of the *Source Book* provides the latest available data on major forms of health insurance: hospital, major medical, disability and dental insurance. Also included is information on medical care costs, morbidity and health manpower in the United States. The data have been compiled from reports of insurance companies and other health insurance plans, government agencies and hospital and medical associations.

The *Source Book* is used as a reference by writers, editors, researchers, educators, government leaders, hospital and medical professionals, business associations and unions, and others interested in health care and its financing.

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Key Health Insurance Statistics

	1980	1984	1985	% Change	
				1984-85	1980-85
Number of Persons with Private Health Insurance Protection in the United States (000 omitted)					
Hospital expense	187,375	184,403	181,329	- 1.7	- 3.2
Major medical expense (Under age 65 only)	N.A.	167,730	162,764	- 3.0	N.A.
Disability income:					
Short-term	68,831	59,332	N.A.	N.A.	N.A.
Long-term	22,051	22,944	25,511	11.2	15.7
Dental expense	79,433	102,159*	99,768*	- 2.3	25.6
Health Insurance Benefit Payments in the United States (000,000 omitted)					
Insurance companies	\$37,002	\$ 55,980	\$ 59,962	7.1	62.1
Blue Cross-Blue Shield and other plans	41,706*	61,765*	70,074*	13.5	68.0
Total†	\$76,320	\$107,522	\$117,609	9.4	54.1
Health Insurance Premiums in the United States†† (000,000 omitted)					
Insurance companies	\$ 43,666	\$ 70,440	\$ 75,169	6.7	72.1
Blue Cross-Blue Shield and other plans	43,674	68,518*	78,199*	14.1	79.1
Total†	\$ 84,742	\$127,635	\$139,525	9.3	64.6
Community Hospital Statistics in the United States					
Average length of hospital stay (days)	7.6	7.3	7.1	- 2.7	- 6.6
Average cost to hospital per patient day	\$ 245.12	\$ 411.10	\$ 460.19	11.9	87.7
Average cost to hospital per patient stay	\$1,850.96	\$2,995.38	\$3,244.74	8.3	75.3

N.A.—Not available.

*Estimate.

†"Total" Benefits and Premiums eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("other plans" data) both reporting administrative service only (ASO) benefits and premiums in their data.

††Data for insurance companies refer to earned premiums. Data for Blue Cross-Blue Shield and other plans refer to earned income.

NOTE: Some data are revised from previous editions.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association, American Hospital Association and the U.S. Department of Health and Human Services.

Chapter 1

Extent of Private Health Insurance Coverage

At the end of 1985, more than 181 million Americans—77% of the civilian noninstitutional population—were protected by one or more forms of private health insurance (Table 1.1).

These included over 167 million persons under 65—representing 80% of this age group. Nearly 14 million older persons—almost 5 in 10 in the 65-and-older population—held private health insurance policies to supplement benefits available through Medicare.

Various forms of private health insurance coverage are available from several different types of insurers: insurance companies, hospital and medical service plans like Blue Cross and Blue Shield, group medical plans operating on a prepayment basis such as health maintenance organizations, and others.

More than 1,200 private insurance companies in the United States were writing individual and/or group health insurance covering over 100 million persons at year-end 1985. Policies issued by insurance companies provide for payment directly to the insured or, if assigned by the insured, to the provider of services for reimbursement of expenses incurred. Health insurance coverage made available by insurance companies can be divided into two basic categories—*medical expense* insurance and *disability income* insurance. *Medical expense* insurance is a “reimbursement type” of coverage which provides broad benefits that can cover virtually all expenses connected with hospital and medical care and related services. *Disability income* insurance provides periodic payments

when the insured is unable to work as a result of sickness or injury.

The Blue Cross and Blue Shield Association coordinates the Blue Cross and Blue Shield plans of the nation. The non-profit member plans service statewide and other geographical areas, offering both individual and group coverage.

Blue Cross plans provide hospital care benefits on essentially a “service type” basis, under which the organization, through a separate contract with member hospitals, reimburses the hospital for covered services provided to the insured.

Blue Shield plans provide benefits for surgical and medical services performed by a physician. The typical Blue Shield plan provides benefits similar to those provided under the benefit provisions of hospital-surgical policies issued by insurance companies. In 1986, there were 13 Blue Cross plans and 15 Blue Shield plans in the United States and 50 joint plans, making a total of 78 Blue Cross and Blue Shield plans.

Health care coverage is also provided through health maintenance organizations (HMOs), which provide comprehensive health care services for their members for a fixed periodic payment. In such plans a group of physicians, surgeons, dentists or optometrists furnish needed care as specified in the contract to subscribers. From mid-1971 to June 1986, the number of operational HMOs increased from 33 to 626 and the number of subscribers increased from 3.6 million to 27.8 million.

Certain types of health insurance coverage are also made available by plans

that are administered by employers or labor unions, fraternal societies, communities, or by rural and consumer health cooperatives. Usually the protection provided by these groups is the amount desired and affordable by a specific group of people.

Some 55% of the total 1985 insurance company group coverage is represented by Administrative Service Only (ASO) arrangements and Minimum Premium Plans (MPPs). Under these systems, corporations and other organizations establish self-funded health plans. Insurance carriers or private organizations are paid a fee by the self-funding group to process the claims and benefits paperwork. Under MPPs, many employers also insure against a certain level of large, unpredictable claims.

Hospital Expense Insurance

At the end of 1985, 181 million persons were covered for hospital expenses by private health insurance (Table 1.2), the most common type of medical expense coverage. This coverage has grown 31% since 1965.

Hospital expense coverage provides specific benefits for daily hospital room and board and usual hospital services and supplies during hospital confinement. Room and board benefits are usually stated in one of two ways: one is reimbursement for the actual room and board charge up to a specified maximum amount per day for hospital confinement. The second provides a service-type benefit that equals the semiprivate room and board charge of the hospital.

Hospital expense benefits are provided in one of three ways: by a hospital expense insurance policy that is often sold in combination with a surgical

expense insurance policy so as to also provide benefits for both surgical operations and doctors' in-hospital visits; by major medical policies that provide broad and substantial coverage for many types of medical expenses; and by hospital indemnity policies.

Hospital indemnity coverage is issued to individuals and provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The money is payable without regard to the actual expense of hospital confinement or the existence of other insurance coverage.

A study by the Health Insurance Association of America examined the extent of health insurance coverage among 14.2 million employees covered under group policies at year-end 1984. The results, published in *A Profile of Group Major Medical Expense Insurance*, show that among the employees with hospital expense coverage, only 17% covered under comprehensive programs had first-dollar (no deductible) coverage and 83% had a deductible applicable.

At year-end 1985, 13.9 million persons over age 65 were covered by private health insurance, including 5.1 million protected by hospital coverage issued through insurance companies.

Major Medical Expense Insurance

Major medical expense insurance—introduced nationally by insurance companies in 1951—has grown rapidly. By the end of 1985, some 163 million persons under 65 years of age had major medical coverage through insurance company policies, Blue Cross-Blue Shield, HMOs and other independent plans (Table 1.3). Insurance companies alone covered 110

million persons under 65 (Table 1.4).

Major medical coverage provides broad and substantial protection for large, unpredictable medical expenses. It covers a wide range of medical charges with few internal limits and a high overall maximum benefit. Basically, there are two types of major medical plans: one supplements basic hospital-surgical-physician's expense insurance programs; the other provides comprehensive protection where both basic coverage and extended health care benefits are integrated.

Virtually all employees surveyed in the HIAA's 1984 *Profile of Group Major Medical Expense Insurance* had at least a maximum benefit of \$50,000 or more. Of the 14.2 million employees covered in the study, 84% were covered under a comprehensive major medical plan and 16% under a major medical plan supplementing a basic medical expense policy. Some 96% of these had a maximum benefit of \$250,000 or more; 79% had a maximum benefit of \$1 million or an unlimited amount; and 99% had a maximum of \$50,000 or more. In 1970, only 15% of employees with major medical expense insurance had a maximum benefit of \$50,000 or more. Over 98% of the employees surveyed had some out-of-pocket limit, the most common being between \$1,000 and \$2,000.

A survey of newly-issued group major medical benefits revealed that of these plans issued by insurance companies in 1986, 90% of surveyed employees had maximum benefits of \$1 million or more. Some 57% had maximums of \$1 million and over, and 33% had unlimited benefits.

Generally, insurance company and

medical plan benefits are subject to some form of deductible and coinsurance payments by the insured.

Disability Income Protection

Disability income benefits provide for the partial replacement of income lost by employees as the result of an accident, illness or pregnancy. Generally, disability income policies are divided into two types—those that provide benefits for up to two years (short-term) and those that provide benefits for a longer period, usually for at least 5 years but often to age 65 or for life (long-term).

The amount of the benefit may vary depending upon whether disability is total or partial, and the duration of benefits may vary depending on whether the disability is the result of an accident or an illness. Some policies include a provision whereby monthly income benefits are increased each year according to a predetermined formula which may be related to the cost of living.

When provided on a group basis, the benefits are usually integrated with benefits from Social Security and other public programs. The total level of benefits from these sources is generally set at a level that does not exceed 60% of salary.

Individual disability income policies usually provide a fixed dollar amount of coverage. This amount may be greater for those who are turned down by Social Security. Individual disability income policies take many forms, designed to fit the special needs of the individual policyowner.

Such policies include Return of Premium, Key Person, Overhead Expense,

and Buy-Sell Policies. Other types of coverage that may include disability income benefits are travel accident, automobile (including no-fault), accidental death and dismemberment and hospital indemnity insurance.

At the end of 1985, 28 million persons had short-term disability protection with private insurance companies. Some 23 million were covered under group policies and approximately 6 million under individual contracts. Almost 26 million people carried long-term disability insurance, which usually provides benefits to age 65 or 70.

Dental Expense Insurance

Dental expense insurance provides reimbursement for expenses of dental services and supplies and encourages preventive care. The coverage normally provides for oral examinations (including X-rays and cleanings), fillings, extractions, inlays, bridgework and dentures, as well as oral surgery, root canal therapy and orthodontics.

Dental coverage is generally available through insurance company group plans, prepayment plans and dental service corporations.

It is estimated that nearly 100 million persons were protected by some form of dental expense insurance at year-end 1985 (Table 1.6).

The largest providers of this type of protection are insurance companies, which insured 62 million persons through group policies at the end of 1985, compared to 19 million in 1975.

Blue Cross-Blue Shield plans, which first offered dental coverage in the late 1960s, covered 14 million persons at the end of 1985. An additional 57 million persons were covered by dental

service corporations, HMOs or through union self-insurance trusts in which union welfare funds directly reimburse dentists in group practice clinics.

The 1984 HIAA *Profile of Group Major Medical Expense Insurance* found that 5.3 million of the 14.2 million employees in the survey had dental expense protection. This represents a smaller percentage than in a 1980 study. Of these, 70% were covered for orthodontia expenses for children and 60% had coverage for adults.

The Uninsured and Underinsured Population

Estimates of the number of persons in the United States without private or public protection against health care expenses have been developed by various private and governmental agencies.

The purpose of this section is to summarize some recent studies. No attempt has been made to analyze the accuracy of the findings due to differences in definitions, methodology and time periods covered.

The U.S. Bureau of the Census¹ in a report for the fourth quarter of 1983 estimated that 85% of the population was covered by either government or private health insurance during this period. The population covered by private health insurance was 75%, and 61% of the total population was covered by a health plan that was related to the current employment of a family member.

The Employee Benefit Research Institute² stated in a 1986 study that 30.3 million people under age 65 in 1982 lacked health insurance coverage from any public or private source. By

1984 (the most recent year for which data are available) the number had risen to 34.7 million.

The most recent report on the uninsured population by the National Center for Health Services Research³ concluded that there are approximately 9 million persons with employment experience that are uninsured; with their uninsured dependents, they account for three-quarters of all persons who lack coverage.

According to a recent report from the U.S. Department of Labor,⁴ the number of uninsured will be affected by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which requires group health plans sponsored by employers with 20 or more employees to offer continuation of coverage under the group plan for terminated or laid-off workers and

their dependents for a period of up to 18 months or 36 months. The employee pays 102% of the full cost of coverage (including the employer's contribution) for active employees. The survey reported that 46% of participants were in firms that either discontinued health insurance immediately upon termination or had no established policy.

1. U.S. Department of Commerce, Bureau of the Census. Current Population Reports, Household Economic Studies P70-83-4. *Economic Characteristics of Households in the United States: Fourth Quarter 1983*.

2. Employee Benefit Research Institute. *Employer-Sponsored Health Insurance Coverage*. EBRI Issue Brief. 1986.

3. National Center for Health Services Research. *The Employed Uninsured and the Role of Public Policy*. 1984.

4. U.S. Department of Labor. Bureau of Labor Statistics. *BLS Reports on Employee Benefits in Medium and Large Firms in 1986*. (Press release) March 31, 1987.

Table 1.1**Number of Persons with Private Health Insurance Protection in the United States by Type of Coverage (000 omitted)**

End of year	Hospital expense	Major medical expense	Disability income		Dental expense†
			Short-term	Long-term	
1940	11,962	—	N.A.	N.A.	—
1945	32,072	—	N.A.	N.A.	—
1950	76,639	—	37,793	*	—
1955	101,400	N.A.	39,513	*	—
1960	122,500	32,590	42,436	*	N.A.
1961	125,825	41,974	43,055	*	N.A.
1962	129,407	48,393	45,002	*	N.A.
1963	133,472	55,382	44,246	3,029	N.A.
1964	136,304	62,112	45,092	3,363	N.A.
1965	138,671	69,666	46,927	4,514	N.A.
1966	142,369	73,843	49,931	5,068	N.A.
1967	146,409	81,550	51,975	6,778	4,570
1968	151,947	87,641	55,636	7,836	5,867
1969	155,025	95,528	57,770	9,282	8,858
1970	158,847	103,544	58,089	10,966	11,972
1971	161,849	108,813	59,280	12,284	15,263
1972	164,098	113,837	61,548	14,538	16,853
1973	168,455	124,627	64,168	17,011	20,418
1974	173,140	131,438	65,282	17,799	27,855
1975	178,180	134,092	62,971	18,396	30,337
1976	176,858	138,657	62,250	17,779	41,703
1977	179,853	139,884	64,627	19,364	50,737
1978	185,690	142,158	68,307	19,100	55,462
1979	185,743	148,805	65,808	19,920	61,608
1980	187,375	153,564	68,831	22,051	79,433
1981	186,193	153,676	65,301	22,582	83,245
1982	188,337	160,056	68,638	25,313	93,112
1983	186,644	159,612	64,146	24,655	100,828
1984	184,403	N.A.	59,332	22,944	102,159
1985					
Under 65	167,441	162,764	N.A.	N.A.	N.A.
65 and over	13,888	N.A.	N.A.	N.A.	N.A.
Total	181,329	N.A.	N.A.	25,511	99,768

N.A.—Not available.

*Included in "Short-term," with the possibility of some duplication of disability income coverage for these years.

†Estimates on dental expense include fully-insured group plans, self-administered plans, plans employing third party administrators, and health maintenance organizations.

NOTE: Some data are revised from previous editions. Data for 1978 and later have been adjusted downward due to new data on average family size. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. The data refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.2
Number of Persons with Hospital Insurance Protection in
the United States by Type of Insurer (000 omitted)

End of year	Insurance Companies					Other plans**
	All insurers*	All insurance companies*	Group policies	Individual and family policies	Blue Cross/Blue Shield	
1940	11,962	3,700	2,500	1,200	6,012	2,250
1945	32,072	10,504	7,804	2,700	18,899	2,670
1950	76,639	36,955	22,305	17,296	38,822	4,445
1955	101,400	53,480	38,620	19,887	50,726	6,545
1960	122,500	69,226	54,416	22,181	58,050	5,994
1961	125,825	70,367	56,077	22,420	58,664	7,102
1962	129,407	72,156	58,057	23,035	60,118	6,937
1963	133,472	74,478	61,448	23,516	61,016	7,165
1964	136,304	75,825	63,011	23,951	62,054	6,840
1965	138,671	77,642	65,415	24,424	63,347	6,984
1966	142,369	80,419	67,799	24,888	65,310	6,633
1967	146,409	82,603	71,454	24,619	67,214	7,050
1968	151,947	85,705	74,073	25,278	70,019	7,277
1969	155,025	88,798	77,973	25,922	72,692	7,702
1970	158,847	89,688	80,505	26,658	75,055	8,131
1971	161,849	91,531	80,641	27,773	76,539	8,545
1972	164,098	93,681	81,526	29,011	78,206	8,053
1973	168,455	94,544	83,626	27,544	81,345	9,562
1974	173,140	97,010	85,385	28,807	83,845	11,072
1975	178,180	99,547	87,185	30,115	86,436	13,145
1976	176,858	97,038	86,824	26,996	86,601	14,868
1977	179,853	100,378	89,219	28,687	86,024	18,106
1978	185,690	105,873	92,624	36,106	85,816	21,489†
1979	185,743	104,084	94,099	34,387	86,148	25,502†
1980	187,315	105,521	97,393	33,763	86,721	33,152†
1981	186,193	105,966	102,975	25,257	85,773†	40,305†
1982	188,337	109,605	103,945	29,375	82,039†	48,246†
1983	186,644	105,942	104,564	22,231	79,600†	53,560†
1984	184,403	103,068	102,978	20,351	79,400†	54,106††
1985						
Under 65	167,441	95,214	97,296	16,665	70,000†	48,952††
65 and over	13,888	5,141	2,229	4,510	8,700†	6,107††
Total	181,329	100,355	99,525	21,175	78,700†	55,059††

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Other plans include self-insured plans, self-administered plans, plans employing third party administrators, and health maintenance organizations.

†Estimate.

††For 1984 and 1985, estimates of persons covered by "other plans" have been developed by HIAA in the absence of other available data.

NOTE: Some data are revised from previous editions. Data for 1978 and later have been adjusted downward due to new data on average family size. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company administrative service only (ASO) agreements and minimum premium plans (MPP) are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.3
Number of Persons with Major Medical Expense Protection
in the United States by Type of Insurer (000 omitted)

End of year	Insurance Companies					Other plans**
	All insurers*	All insurance companies*	Group policies	Individual and family policies	Blue Cross/Blue Shield	
1951	N.A.	108	96	12	N.A.	N.A.
1955	N.A.	5,241	4,759	482	N.A.	N.A.
1960	32,590	25,371	26,454	1,607	3,713	N.A.
1961	41,974	32,334	34,339	2,372	5,059	N.A.
1962	48,393	37,130	39,081	2,949	7,501	N.A.
1963	55,382	42,003	44,006	3,459	10,000	N.A.
1964	62,112	47,338	49,166	4,185	12,500	N.A.
1965	69,666	53,020	55,412	4,456	14,600	N.A.
1966	73,843	57,881	60,984	4,516	14,352	N.A.
1967	81,550	63,428	67,394	4,552	16,279	N.A.
1968	87,641	68,171	72,436	4,873	17,807	N.A.
1969	95,528	73,752	78,165	5,377	20,328	N.A.
1970	103,544	77,061	81,962	5,414	24,905	N.A.
1971	108,813	80,252	85,553	5,479	26,780	N.A.
1972	113,837	83,668	87,806	6,630	30,082	N.A.
1973	124,627	87,839	91,915	7,310	37,328	N.A.
1974	131,438	91,044	95,532	7,235	40,862	N.A.
1975	134,092	92,166	96,718	7,315	42,058	N.A.
1976	138,657	93,191	98,355	6,672	41,670	11,156
1977	139,884	96,003	101,925	6,101	39,390	14,005
1978	142,158	101,877	108,241	6,847	39,317	17,201†
1979	148,805	103,281	109,524	7,222	43,341	21,125†
1980	153,564	105,352	113,002	7,330	45,000	27,733†
1981	153,676	104,943	113,170	6,467	46,500	33,717†
1982	150,056	108,660	116,220	8,018	47,000†	42,604†
1983						
Under 65 only	159,612	108,913	117,596	6,541	44,600†	42,798†
1984						
Under 65 only	167,730	115,351	125,507	5,613	44,500†	47,037††
1985						
Under 65 only	162,764	110,232	119,567	5,872	44,100†	47,866††

N.A.—Not available.

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Other plans include self-insured plans, self-administered plans, plans employing third party administrators, and health maintenance organizations.

†Estimate.

††For 1984 and 1985, estimates of persons covered by "other plans" have been developed by HIAA in the absence of other available data.

NOTE: Some data are revised from previous editions. Data for 1978 and later have been adjusted downward due to new data on average family size. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company administrative service only (ASO) agreements and minimum premium plans (MPP) are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.4
Number of Persons with Major Medical Expense Protection
with Insurance Companies in the United States by Type of
Policy (000 omitted)

End of year	Insurance company total*	Group policies			Individual and family policies
		Net total*	Supple- mentary	Compre- hensive	
1951	108	96	96	—	12
1955	5,241	4,759	3,928	831	482
1960	25,371	24,429	17,991	8,463	1,607
1961	32,334	30,729	24,488	9,851	2,372
1962	37,130	35,002	28,445	10,636	2,949
1963	42,003	39,446	32,307	11,699	3,459
1964	47,338	44,087	36,925	12,241	4,185
1965	53,020	49,700	42,450	12,962	4,456
1966	57,881	54,732	46,830	14,154	4,516
1967	63,428	60,517	51,824	15,570	4,552
1968	68,171	65,076	55,422	17,014	4,873
1969	73,752	70,272	58,905	19,260	5,377
1970	77,061	73,702	61,718	20,244	5,414
1971	80,252	76,971	63,442	22,111	5,479
1972	83,668	79,025	64,443	23,363	6,630
1973	87,839	82,724	66,225	25,690	7,310
1974	91,044	85,979	67,911	27,621	7,235
1975	92,166	87,046	67,310	29,408	7,315
1976	93,191	88,520	66,753	31,602	6,672
1977	96,003	91,733	68,349	33,576	6,101
1978	101,877	97,504	N.A.	N.A.	6,847
1979	103,281	98,663	N.A.	N.A.	7,222
1980	105,352	100,719	N.A.	N.A.	7,330
1981	104,943	100,865	N.A.	N.A.	6,467
1982	108,660	103,548	N.A.	N.A.	8,018
1983					
Under 65 only	108,913	104,660	66,171	51,425	6,541
1984					
Under 65 only	115,351	111,701	68,935	56,572	5,613
1985					
Under 65 only	110,232	106,415	56,717	62,850	5,872

N.A.—Not available.

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

NOTE: Some data are revised from previous editions. Data for 1978 and later have been adjusted downward due to new data on average family size. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company administrative service only (ASO) agreements and minimum premium plans (MPP) are included in the categories "All insurance companies" and "Group policies."

SOURCE: Health Insurance Association of America.

Table 1.5
Number of Persons with Disability Income Protection by
Type of Program in the United States (000 omitted)

End of year	All programs	Insurance Companies			Formal paid sick leave plans	Employee union and association plans
		All insurance companies	Group policies	Individual policies		
1946	26,229	14,369	7,135	8,684	8,400	3,460
1950	37,793	25,993	15,104	13,067	8,900	2,900
1955	39,513	29,813	19,171	13,642	8,500	1,200
1960	42,436	31,836	20,970	14,298	9,500	1,100
Short-Term Disability Income Protection						
1965	46,927	33,527	22,409	11,937	11,700	1,700
1970	58,089	39,789	27,876	14,901	15,900	2,400
1971	59,280	40,180	28,408	13,866	16,500	2,600
1972	61,548	41,208	29,151	14,527	17,640	2,700
1973	64,168	43,298	29,279	16,890	18,170	2,700
1974	65,282	43,672	29,320	17,291	18,910	2,700
1975	62,971	41,071	28,607	15,024	19,400	2,500
1976	62,250	38,940	27,534	13,742	20,610	2,700
1977	64,627	40,047	28,176	14,302	21,880	2,700†
1978	68,307	43,289	28,676	17,606	22,318	2,700†
1979	65,808	40,208	27,005	15,907	22,900†	2,700†
1980	68,831	42,431	29,718	15,209	23,700†	2,700†
1981	65,301	38,201	29,454	10,539	24,400†	2,700†
1982	68,638	41,138	32,465	10,450	24,800†	2,700†
1983	64,146	36,446	28,576	9,482	25,000†	2,700†
1984	59,332	31,632	24,686	8,369	25,000†	2,700†
1985	N.A.	28,308	23,299	6,035†	N.A.	N.A.
Long-Term Disability Income Protection						
1965	4,514	4,514	1,864	2,650	—	—
1970	10,966	10,966	6,954	4,012	—	—
1971	12,284	12,284	7,951	4,333	—	—
1972	14,538	14,538	9,471	5,067	—	—
1973	17,011	17,011	10,595	6,416	—	—
1974	17,799	17,799	11,116	6,683	—	—
1975	18,396	18,396	11,526	6,870	—	—
1976	17,779	17,779	11,516	6,263	—	—
1977	19,364	19,364	12,481	6,883	—	—
1978	19,100	19,100	12,635	6,465	—	—
1979	19,920	19,920	13,409	6,511	—	—
1980	22,051	22,051	15,651	6,400	—	—
1981	22,582	22,582	16,825	5,757	—	—
1982	25,313	25,313	19,163	6,150	—	—
1983	24,655	24,655	19,148	5,507	—	—
1984	22,944	22,944	17,359	5,585	—	—
1985	25,511	25,511	19,644	5,867	—	—

†Estimate.

NOTE: For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Data in the category "Insurance companies" refers to the net total of people protected, i.e., duplication among persons who are covered by both group and individual policies has been eliminated. Any duplication resulting from the combination of numbers covered for short-term and long-term protection has not been eliminated. For 1980 and later, this category includes administrative service only (ASO) agreements and minimum premium plans (MPP). The category "Formal paid sick leave plans" refers to people with formal paid sick leave plans but without insurance company coverage. Data exclude plans that are both self-administered and self-insured.

SOURCES: Health Insurance Association of America and the U.S. Department of Health and Human Services.

Table 1.6
Number of Persons with Dental Expense Protection in the
United States by Type of Insurer (000 omitted)

End of year	All insurers*	Insurance companies**	Blue Cross/Blue Shield	Other plans***
1967	4,570	2,330	20	2,220
1968	5,867	3,170	35	2,662
1969	8,858	5,159	141	3,558
1970	11,972	7,383	275	4,314
1971	15,263	8,841	1,100	5,322
1972	16,853	10,200	1,110	5,543
1973	20,418	12,097	1,740	6,581
1974	27,855	16,756	3,790	7,309
1975	30,337	18,936	3,318	8,290
1976	41,703	26,562	4,363	11,105
1977	50,737	32,216	5,283	14,234
1978	55,462	36,401	6,800†	17,827†
1979	61,608	42,847	7,100†	22,327†
1980	79,433	54,836	10,000†	27,225†
1981	83,245	59,449	10,400†	35,531†
1982	93,112	66,582	9,100†	44,845†
1983	100,828	69,684	10,400†	51,600†
1984	102,159	66,657	12,600†	55,785††
1985	99,768	62,474	13,800†	56,768††

*For 1975 and later, the data in this column refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance policy providing the same type of coverage has been eliminated.

**Insurance company data are group plans.

***Other plans include self-administered, self-insured plans, plans employing third party administrators, and health maintenance organizations.

†Estimate.

††For 1984 and 1985, estimates of persons covered by "other plans" have been developed by HIAA in the absence of other available data.

NOTE: Some data are revised from previous editions. Data for 1978 and later have been adjusted downward due to new data on average family size. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.



Chapter 2

Health Insurance Benefit Payments

A total of \$117.6 billion in health insurance benefits was paid by private insuring organizations in the United States in 1985 (Table 2.1), a 9.4% increase over 1984 and more than three and one half times the amount paid 10 years earlier. The increase was mainly because of the rising cost of medical care, expansion of benefits and higher utilization.

Medical expense benefits, which include payments under hospital, surgical, physician's expense and major medical insurance, totaled \$103.2 billion in 1985, an increase of 9% over 1984. Dental expense benefits for 1985 totaled \$8.8 billion.

Health insurance benefits are provided by private insurers in two ways: through indemnity payments or through service arrangements.

Benefits by insurance companies are primarily provided through indemnity payments, whereby the insured person is paid a specified sum of money toward his covered expenses. (Payments can also be made directly to the provider of care through an assignment of benefits.)

Blue Cross-Blue Shield and other plans usually make direct payments for covered services to the participating hospital or physician.

The numbers in this chapter refer to benefits paid in the current year and include amounts paid for claims of prior years. However, they exclude amounts which will be paid the following year for claims submitted in the current year. Since the premium figures in the next chapter are reported on an earned basis for the calendar year, thereby reflecting a true picture of premiums for the year, it is not appropriate to compare benefit and premium figures.

A comparison of the benefit and premium figures for loss of income policies is particularly inappropriate. Additions to claim reserves for persons already disabled are extracted from current year premiums but not reflected in the benefit payments. These claim reserves will be used to make income payments for all future years of disability included in coverage under the contracts.

Table 2.1**Health Insurance Benefit Payments by Type of Insurer and by Type of Coverage in the United States (000,000 omitted)**

	Year	Total	Hospital-medical expense	Dental expense	Loss of income*
All Insurers††	1950	\$ 1,347	N.A.	N.A.	\$ 383
	1955	3,142	\$ 2,547	**	595
	1960	5,676	4,837	**	839
	1965	9,624	8,578	**	1,046
	1970	17,177	15,127	\$ 233	1,817
	1975	32,081	28,494	880	2,707
	1980	76,320	65,936	5,042	5,342
	1981	85,884	74,677	6,051	5,156
	1982	97,135	84,966	6,640	5,529
	1983	104,085	91,892	7,300	4,893
	1984	107,522	94,648	7,714	5,160
	1985	117,609	103,187	8,788	5,634
Insurance Companies	1950	755	372	**	383
	1955	1,785	1,190	**	595
	1960	3,069	2,230	**	839
	1965	5,160	4,114	**	1,046
	1970	9,089	7,132	140	1,817
	1975	16,470	13,164	599	2,707
	1980	37,002	28,865	2,795	5,342
	1981	41,622	32,992	3,474	5,156
	1982	49,159	39,646	3,984	5,529
	1983	51,665	42,400	4,372	4,893
	1984	55,980	45,907	4,913	5,160
	1985	59,962	49,036	5,292	5,634
Blue Cross/ Blue Shield and Other Plans†††	1950	590	N.A.	N.A.	—
	1955	1,357	1,357	**	—
	1960	2,607	2,607	**	—
	1965	4,464	4,464	**	—
	1970	8,088	7,995	93	—
	1975	16,932†	16,362	570†	—
	1980	41,706†	39,238	2,468†	—
	1981	48,154†	45,211†	2,943†	—
	1982	53,721†	50,508†	3,213†	—
	1983	58,453†	54,841†	3,612†	—
	1984	61,765†	57,740†	4,025†	—
	1985	70,074†	65,134†	4,940†	—

N.A.—Not available.

*Insurance company coverage only.

**Included in "Hospital-medical expense."

†Estimate.

††Benefits for "All Insurers" eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other plans" data) both reporting administrative service only (ASO) benefits in their data.

†††Other plans include self-administered, self-insured plans, plans employing third party administrators and health maintenance organizations.

NOTE: Some data are revised from previous editions. For 1975 and later, data include benefit payments in Puerto Rico and U.S. territories and possessions. Figures do not add to totals in some cases due to rounding. "Medical expense" includes payments for hospital, medical expense other than hospital and major medical benefits. Insurance company benefit payments for 1975 and later include administrative service only (ASO) agreements and minimum premium plans (MPP). Amounts in prior years contained only a portion of this data.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 2.2
Health Insurance Benefit Payments of Insurance Companies
in the United States (000,000 omitted)

Year	Grand total	Group				Individual and family policies		
		Total group	Hospital-medical expense	Dental	Loss of income	Total	Hospital-medical expense	Loss of income
1945	\$ 278	\$ 139	N.A.	N.A.	N.A.	\$ 139	N.A.	N.A.
1950	755	438	N.A.	N.A.	N.A.	317	N.A.	N.A.
1955	1,785	1,252	N.A.	N.A.	N.A.	533	N.A.	N.A.
1960	3,069	2,350	\$ 1,809	*	\$ 541	719	\$ 421	\$ 298
1961	3,394	2,616	2,082	*	534	778	457	321
1962	3,763	2,911	2,338	*	573	852	519	333
1963	4,152	3,203	2,614	*	589	948	601	347
1964	4,658	3,585	2,953	*	632	1,073	693	380
1965	5,160	4,000	3,321	*	679	1,160	792	368
1966	5,559	4,357	3,608	*	749	1,203	814	389
1967	6,030	4,790	3,953	\$ 42	796	1,239	824	415
1968	6,717	5,362	4,360	54	948	1,355	894	461
1969	7,575	6,202	5,027	79	1,096	1,374	897	476
1970	9,089	7,476	6,043	140	1,293	1,613	1,090	523
1971	9,498	8,018	6,541	175	1,301	1,480	1,006	474
1972	10,622	8,943	7,315	201	1,427	1,679	1,148	531
1973	11,863	9,764	7,924	262	1,578	2,099	1,462	637
1974	13,636	11,439	9,260	332	1,847	2,197	1,517	680
1975	16,470	14,191	11,607	599	1,985	2,279	1,557	722
1976	20,217	17,795	14,425	1,187	2,183	2,422	1,691	731
1977	22,113	19,479	15,683	1,452	2,344	2,634	1,869	765
1978	26,352	22,868	18,696	1,771	2,401	3,484	2,480	1,004
1979	31,692	27,934	22,159	2,185	3,590	3,758	2,644	1,114
1980	37,002	33,002	25,895	2,795	4,312	4,000	2,970	1,030
1981	41,622	37,691	30,057	3,474	4,160	3,931	2,935	996
1982	49,159	44,202	36,074	3,984	4,144	4,957	3,572	1,385
1983	51,665	46,890	38,649	4,372	3,869	4,775	3,751	1,024
1984	55,980	50,305	41,485	4,913	3,907	5,675	4,422	1,253
1985	59,963	53,669	44,340	5,292	4,037	6,293	4,696	1,597

N.A.—Not available.

*Included in "Hospital-medical expense."

NOTE: For 1975 and later, data include benefit payments in Puerto Rico and U.S. territories and possessions. Insurance company benefit payments for 1975 and later include administrative service only (ASO) agreements and minimum premium plans (MPP). Aggregates in prior years contained only a portion of these data. Figures do not add to totals in some cases due to rounding.

SOURCE: Health Insurance Association of America.



Chapter 3

Health Insurance Premium Income

In 1985, health insurance premium income of all private insuring organizations was \$139.5 billion. Americans spent the equivalent of 4.91% of disposable personal income (personal income less personal taxes) in 1985 for health insurance premiums, compared with 4.78% in 1984 (Table 3.1).

Insurance company premiums reported in Tables 3.1 and 3.2 are on an earned basis for the calendar year. (Earned premiums are defined as the calendar-year portion of premiums for which the protection of the policy has been provided.)

Because benefit data in the preceding chapter refer to paid benefits and do not include estimates for reserve and liability items, it is inappropriate to compare those benefit data to premium data in this chapter.

Insurance companies earned \$75.2 billion in premiums in 1985.

Group and Individual Premiums

Group health insurance premiums paid to private insuring organizations have been increasing substantially for many years. This growth is attributable to the extension of health insurance coverage to small groups not previously eligible and to the need to fund larger benefit levels to meet health care cost increases. In 1985, insurance companies earned \$64.4 billion in group premiums—some 85.6% of total insurance premiums—and \$10.8 billion in individual and family policy premiums.

Table 3.1
Health Insurance Premiums and Ratio to Disposable
Personal Income (000,000 omitted)

Premium Income of Insurance Companies, Subscription Income of Blue Cross/Blue Shield and Other Plans in the United States

Year	Insurance companies	Blue Cross/ Blue Shield and other plans	Total premiums**	Disposable personal income	Ratio
1940	\$ 286	\$ 32	\$ 318	\$ 75,328	0.42%
1945	550	154	704	149,118	0.47
1950	1,266	687	1,953	207,450	0.94
1955	2,743	1,523	4,266	278,775	1.53
1960	4,671	2,814	7,485	358,900	2.09
1961	5,029	3,246	8,275	373,750	2.21
1962	5,595	3,601	9,196	396,150	2.32
1963	6,145	3,918	10,063	415,825	2.42
1964	6,769	4,332	11,101	451,425	2.46
1965	7,352	4,777	12,129	486,800	2.49
1966	7,796	4,969	12,765	525,900	2.43
1967	8,295	5,247	13,542	562,075	2.41
1968	9,082	5,966	15,048	609,575	2.47
1969	10,197	7,089	17,286	656,675	2.63
1970	11,546	8,439	19,985	715,600	2.79
1971	12,777	10,058	22,835	776,800	2.94
1972	14,771	11,465	26,236	839,575	3.12
1973	16,104	12,908	29,012	949,775	3.05
1974	17,915	14,533	32,448	1,038,350	3.12
1975	20,795*	17,611	36,967	1,142,775	3.23
1976	24,502*	21,455	43,468	1,252,625	3.47
1977	28,676*	25,333	50,449	1,379,325	3.66
1978	32,713*	32,517	63,067	1,551,225	4.07
1979	37,941*	37,625	73,930	1,729,275	4.28
1980	43,666*	43,674	84,742	1,917,900	4.42
1981	48,998*	50,460†	95,136	2,127,600	4.47
1982	58,341*	57,222†	109,472	2,261,425	4.84
1983	63,190*	63,188†	119,876	2,428,100	4.94
1984	70,440*	68,518†	127,635	2,668,600	4.78
1985	75,169*	78,199†	139,525	2,841,100	4.91

*Insurance company premiums for 1975 and later include administrative service only (ASO) agreements and minimum premium plans (MPP). Aggregates in prior years contained only a portion of these data.

**"Total Premiums" eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other plans" data) both reporting administrative service only (ASO) premium equivalencies in their data.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include premiums paid in Puerto Rico and U.S. territories and possessions. Data for "Insurance companies" prior to 1972 refer to written premiums (which, for group policies, include minor adjustments to reflect premiums of the particular year). "Insurance companies" premiums for 1972 and later refer to earned premiums and are revised to exclude premiums for accidental death and dismemberment and other such limited coverages. Data for Blue Cross/Blue Shield and other hospital-medical plans refer to earned income. Data for Blue Cross/Blue Shield for 1974 and later include premium taxes.

SOURCES: U.S. Department of Health and Human Services, *Argus Health Chart*, U.S. Department of Commerce, Health Insurance Association of America, and Blue Cross and Blue Shield Association.

Table 3.2
Health Insurance Premiums of Insurance Companies in the
United States by Type of Policy and by Type of Protection
 (000,000 omitted)

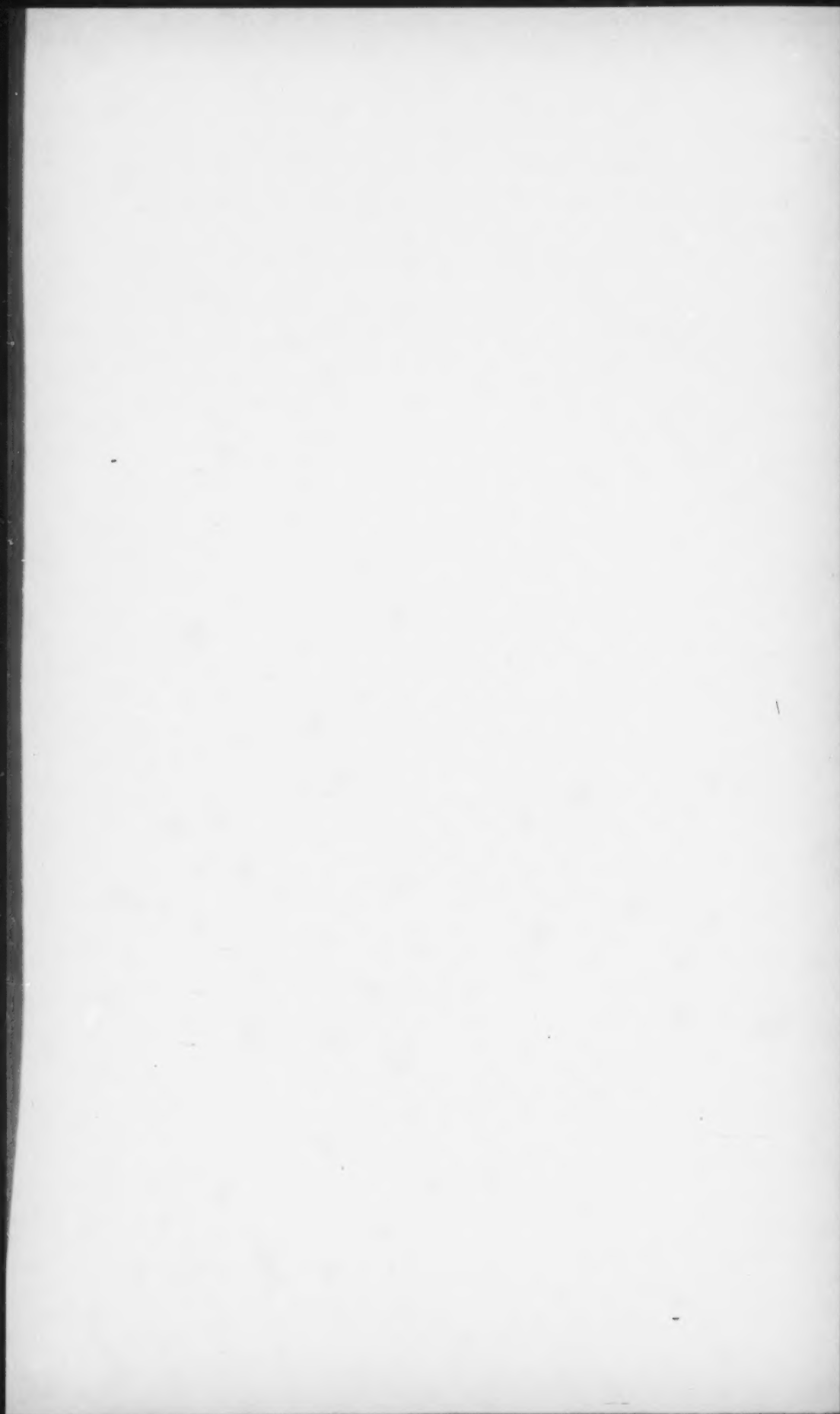
Year	Total premiums	Group policies			Individual and family policies		
		Total	Loss of income	Hospital-medical	Total	Loss of income	Hospital-medical
1935	\$ 175	\$ 26	\$ 26	*	\$ 149	N.A.	N.A.
1940	286	65	48	\$ 17	221	N.A.	N.A.
1945	550	215	125	90	335	N.A.	N.A.
1950	1,266	629	291	338	637	\$ 361	\$ 276
1955	2,743	1,573	553	1,020	1,170	554	616
1960	4,671	2,895	777	2,118	1,776	744	1,032
1965	7,352	4,683	1,050	3,633	2,669	847	1,822
1966	7,796	5,054	1,183	3,871	2,742	886	1,856
1967	8,295	5,464	1,270	4,194	2,831	948	1,883
1968	9,082	6,088	1,473	4,615	2,994	1,018	1,976
1969	10,197	6,938	1,724	5,214	3,259	1,131	2,128
1970	11,546	8,149	1,968	6,181	3,397	1,104	2,293
1971	12,777	9,170	2,189	6,981	3,607	1,154	2,453
1972	14,771	10,946	2,332	8,614	3,825	1,097	2,728
1973	16,104	11,807	2,414	9,393	4,297	1,304	2,993
1974	17,915	13,193	2,603	10,590	4,722	1,445	3,277
1975	20,795	15,918	2,828	13,090	4,877	1,807	3,070
1976	24,502	19,366	3,144	16,222	5,136	1,854	3,282
1977	28,676	23,234	3,543	19,691	5,442	1,859	3,583
1978	32,713	26,939	4,539	22,400	5,774	1,990	3,784
1979	37,941	31,724	4,933	26,791	6,217	2,096	4,121
1980	43,666	36,801	5,277	31,524	6,865	1,956	4,909
1981	48,998	42,465	5,240	37,225	6,533	1,834	4,699
1982	58,341	50,031	5,499	44,532	8,310	2,533	5,777
1983	63,190	54,939	5,099	49,840	8,251	1,993	6,258
1984	70,440	60,841	5,006	55,835	9,599	2,374	7,225
1985	75,169	64,366	4,836	59,530	10,803	2,917	7,886

N.A.—Not available.

*Less than \$500,000.

NOTE: For 1975 and later, data include premiums paid in Puerto Rico and U.S. territories and possessions. Insurance company premiums for 1975 and later include administrative service only (ASO) agreements and minimum premium plans (MPP). Aggregates in prior years contain only a portion of these data. Data prior to 1972 refer to written premiums (which, for group policies, include minor adjustments to reflect premiums of the particular year) and include accidental death and dismemberment premiums in the "Loss of income" categories. Data for 1972 and later refer to earned premiums and are revised to exclude premiums for accidental death and dismemberment and other such limited coverages.

SOURCE: Health Insurance Association of America.



Chapter 4

Federal, State and Local Government Health Care Programs

Medical and health care services are provided through a variety of public programs by all levels of government. In addition, the federal, state and local government agencies often fund research projects and construct medical facilities with public funds. Of the \$425.0 billion in National Health Care Expenditures in 1985 (see Chapter 5), \$174.8 billion was spent for health and medical care programs at all levels of government (Table 4.1).

As the number of programs funded by public monies has multiplied and expanded, so, too, has the public share of national health expenditures. In fiscal 1975, governmental expenditures for health care were 42.5% of national health expenditures, compared to 41.1% in 1985. The introduction of Medicare produced the largest single-year increase in 1967, during which governmental expenditures rose from 29.3% to 36.8% of national health expenditures.

Federal Programs

Prior to 1967, federal health expenditures were less than half of total government expenditures for health care. In 1985, federal expenditures for health care were more than double state and local expenditures.

The majority of federal health spending is for health services to six major groups: low-income individuals and others eligible for Medicaid services, those over 65 (Medicare), military personnel and their dependents,

veterans, federal civilian employees, and native Americans.

Medicaid. Title XIX of the Social Security Act provides for a program of medical assistance for certain low-income individuals and families. The program, known as Medicaid, became federal law in 1965.

Medicaid is basically administered by each state within certain broad federal requirements and guidelines. The program is financed jointly by state and federal funds and is designed to provide medical assistance to those groups or categories of persons who are eligible to receive payment under one of the cash assistance programs (i.e., Aid to Families with Dependent Children and Supplemental Security Income). In addition, states may provide Medicaid to the "medically needy," that is, to persons who fit into one of the categories eligible for public assistance, who have enough income to pay for their basic living expenses but not enough to pay for their medical care.

Many members of the Medicaid population are aged or disabled and are also covered by Medicare. In cases where this dual coverage exists, most state Medicaid programs pay for the Medicare premiums, deductibles and copayments, and for services not covered by Medicare.

In order to qualify for federal matching funds, state programs must include: inpatient hospital services; outpatient hospital services; laboratory and

X-ray services; skilled nursing and home health services for individuals aged 21 and older; family planning services; early and periodic screening, diagnosis and treatment for children under 21; and physicians' services at home, in the office, hospital, nursing home or elsewhere.

In 1985, the Medicaid program paid \$37.5 billion in benefits to 21.8 million recipients. (Table 4.4).

State participation in the Medicaid program is optional. Currently, all states except Arizona participate in the Medicaid program. The District of Columbia, Guam, Puerto Rico, the Virgin Islands and the Northern Mariana Islands also provide Medicaid coverage.

Medicare. Medicare, which became effective July 1, 1966, is a federally administered program that provided hospital and medical insurance protection for over 31 million persons in 1985—those aged 65 and older, persons under age 65 who have been receiving cash benefits under the Social Security or Railroad Retirement programs because they are disabled, and certain chronic kidney disease patients under age 65. Medicare consists of two parts: compulsory hospitalization insurance (HI), also called Part A; and voluntary supplementary medical insurance (SMI), Part B, which helps pay for physicians' services and some medical services and supplies not covered under Part A. Part A is financed by contributions from employers and employees; Part B is voluntary and is financed by monthly premiums paid by those who choose to enroll and by the federal government.

As of January 1, 1987, the out-of-

pocket deductible for Part A of Medicare rose to \$520 (from \$492) for the first 60 days' hospitalization and \$130 per day (from \$123) for the 61st through the 90th day and \$260 per day for lifetime reserve days.

Part B provides benefits equal to 80% of allowed medical-surgical charges after the insured has paid a \$75 deductible amount toward those charges. An individual's monthly premium is \$17.90.

Prior to 1973, aliens and some federal civil service employees and annuitants were not eligible for Part A of Medicare even though they were age 65 or older. In 1973, the law was amended to allow them to enroll in Part A by paying a monthly premium. The premium, \$226 a month, is based on the full cost of hospital care for a high-risk group. These individuals have always had the option of enrolling in Part B.

Since the first full year of Medicare in 1967, benefits paid have increased from \$4.5 billion to \$70.4 billion in 1985, an increase of 1447% (Table 4.3). Part of the increase is because of the eligibility of certain disabled persons beginning in 1973, so that in 1985 nearly 12% of total benefits paid went to individuals either blind or disabled. Benefits paid under Part A totaled \$47.4 billion in 1985, of which \$42.1 billion went to those aged 65 and older. Part B paid \$22.9 billion, of which \$20.1 billion went to the elderly.

Insurance companies, Blue Cross-Blue Shield plans and other independent organizations participate as fiscal intermediaries for the government. In 1986, five private health insurance companies served as fiscal intermediaries for Part A of Medicare, in 45

states and the District of Columbia. Twelve companies distributed benefits under Part B as fiscal intermediaries in 24 states.

On October 1, 1985, 1,500 hospitals came under the Medicare prospective payment system (PPS) for hospitals. Currently, nearly 6,000 hospitals are under the system. These hospitals are subject to legislation that radically restructures the manner in which hospitals are paid for inpatient services provided to Medicare beneficiaries.

All hospitals with an agreement to participate in Medicare are covered under the PPS, except: psychiatric hospitals; rehabilitation hospitals; children's hospitals; long term care hospitals; distinct psychiatric and rehabilitation units; hospitals in the U.S. territories; and a group of hospitals in the states with an approved waiver.

The cornerstone of the PPS and the basis for payment is the diagnosis-related grouping (DRG) system developed by Yale University researchers in the 1970's as a mechanism for utilization review. DRGs are derived from taking all the possible diagnoses identified in the International Classification of Diseases (ICD-9-CM) system, classifying them into 23 major diagnostic categories (MDCs) based on organ systems, and further breaking them into 470 distinct groupings.

Military Personnel and Dependents. All active and retired military personnel and their dependents are eligible for medical treatment at any Department of Defense (DOD) installation medical facility. Additionally, DOD operates the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to provide reim-

bursement (after payment of a deductible) for covered medical care provided in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel (unless eligible for Part A of Medicare). The program is designed for those unable to use government medical facilities because of distance, overcrowded facilities or the unavailability of appropriate treatment at a military medical center.

Of the \$10 billion budgeted for medical care by the Department of Defense in fiscal 1986, \$1.7 billion is for medical services reimbursed through CHAMPUS.

Federal Civilian Employees. Civilian employees of the federal government may participate in a variety of insurance programs (including HMOs) through the payment of biweekly premiums by the employing agency and the employee. Nearly 3.8 million federal civilian employees and annuitants were enrolled in 1985, and 4.9 million dependents were also insured in that year. Most annuitants who were covered under the Federal Employees Health Benefits Program when they were employed by the Federal government may elect to continue this coverage. Annuitants already retired when the program became effective in 1960 are eligible to participate in the Retired Federal Employees Health Benefits Program, which, among other options, provides for government payment of the premium for Medicare Part B. Of the 74,231 retirees enrolled in this program on June 30, 1985, 50% had chosen the Medicare Part B option.

The remainder were covered under private plans.

In addition to federal payment of the employer contributions under these programs, the federal government also incurs administrative expenses and operates in some federal agencies' in-plant health care facilities for federal civilian employees.

Federal expenditures for these federal civilian health programs in fiscal 1985 were nearly \$4.2 billion.

Veterans' Medical Care. The Veterans Administration (VA) operates 172 medical centers and 230 outpatient clinics for the care of individuals with active service in the armed forces who were discharged from duty other than dishonorably. Priority is given to patients with service-related ailments. Of the \$27.1 billion budgeted by the federal government for VA medical activities in 1986, \$9.1 billion was for medical care and hospital services.

Inpatient care was provided to approximately 1.3 million veterans in 1986.

Indian Health Services. A total of \$821 million in federal funds was appropriated to provide health services to 1 million American Indians and Alaskan natives in 1986. The services included hospital care and other medical services; the construction of hospitals, sanitation facilities and housing for health service employees; health manpower training and education; health planning; and research.

Workers' Compensation Medical Care. The federal government in 1985 paid \$300 million of the \$8.2 billion in hospital and medical benefits and

administrative expenses under Workers' Compensation laws in the various states (Table 4.5). Hospital and medical costs amounted to about one-third of all Workers' Compensation expenditures.

State and Local Programs

In fiscal year 1984, state and local public health agencies in 46 states reported \$6.9 billion was spent on public health programs. Some \$3.2 billion came from state funds, and \$2.2 billion from federal grants and contracts. These figures do not include Medicaid expenditures or funds expended for public health purposes by other state agencies. Expenditures include \$1.3 billion for grants to local health departments (LHD) and \$1.1 billion spent by the LHDs from sources other than State Health Agencies (SHA).

Not all SHAs perform the same services. In some states certain services are performed by other state agencies. For example, expenditures for mental health services may be controlled by a separate mental health agency.

The public health programs of SHAs can be divided into four program areas, apart from general administrative and service functions: personal health, environmental health, health resources and laboratory services.

Around 74% of SHA expenditures in 1984 (the latest year for which data are available) were for personal health in nine areas: general and supporting personal health, maternal and child health, communicable disease, handicapped children, dental health, chronic disease, mental health and related programs, SHA operated institutions,

and other personal health (for instance, home health care and services to special population groups such as migrants).

There were some 2,200 local health

departments in 1984. The territories and possessions (except Puerto Rico and American Samoa) three states and the District of Columbia do not have LHDs.

Table 4.1
Federal, State and Local Government Expenditures for
Health and Medical Care

Year	Amount (in billions)			Total per capita	Total as percent of all national health care expenditures (public & private)
	Federal	State and local	Total		
1950	\$ 1.6	\$ 1.8	\$ 3.4	\$ 22	26.8%
1955	2.0	2.6	4.6	27	26.0
1960	3.0	3.6	6.6	36	24.5
1965	5.5	5.5	11.0	54	26.2
1966	7.4	6.1	13.6	66	29.3
1967	11.9	7.0	19.0	91	36.8
1968	14.1	8.0	22.1	105	38.0
1969	16.1	8.9	24.9	117	38.0
1970	17.7	10.1	27.8	129	37.0
1971	20.3	11.4	31.6	146	37.9
1972	22.9	12.5	35.4	161	37.7
1973	25.2	14.2	39.4	178	38.1
1974	30.4	16.6	47.0	211	40.5
1975	37.0	19.3	56.3	250	42.5
1976	42.5	20.3	62.8	277	41.6
1977	47.4	22.4	69.8	305	41.1
1978	53.8	25.8	79.6	345	42.0
1979	61.0	29.5	90.5	388	42.1
1980	71.0	34.2	105.2	447	42.4
1981	83.3	37.9	121.2	510	42.2
1982	93.2	42.1	135.3	563	41.8
1983	102.7	44.8	147.5	608	41.3
1984	111.7	47.8	159.5	652	40.9
1985	124.4	50.4	174.8	708	41.1

NOTE: Detail may not add to totals due to rounding.

SOURCE: Health Care Financing Administration, *Health Care Financing Notes*, September 1986.

Table 4.2
Medicaid Recipients and Benefits Paid By Federal and State Governments* (000,000 omitted)

Fiscal year	Total		Age 65 and over		Dependent children†		All others	
	Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid
1972	17.6	\$ 6,300	3.3	\$ 1,925	11.0	\$2,101	3.3	\$ 2,274
1973	19.6	8,639	3.5	3,235	12.7	2,872	3.4	2,532
1974	21.5	9,983	3.7	3,691	13.9	3,398	3.9	2,893
1975	22.0	12,242	3.6	4,358	14.1	4,248	4.3	3,637
1976	22.8	14,091	3.6	4,910	14.7	4,719	4.5	4,462
1977	22.8	16,239	3.6	5,499	14.4	5,216	4.8	5,524
1978	22.0	17,992	3.4	6,308	14.0	5,421	4.6	6,264
1979	21.5	20,472	3.4	7,046	13.7	5,905	4.5	7,520
1980	21.6	23,311	3.4	8,739	14.2	6,354	4.4	8,217
1981	22.0	27,204	3.4	9,926	14.8	7,271	4.4	10,007
1982	21.6	29,399	3.2	10,739	14.9	7,566	4.3	11,094
1983	21.6	32,391	3.4	11,954	15.1	8,323	4.1	12,114
1984	21.6	33,895	3.2	12,819	15.3	8,400	4.1	12,675
1985	21.8	37,507	3.1	14,096	15.3	9,160	3.4	14,251

*Excludes territories and possessions.

†Includes adults in families with dependent children.

NOTE: Detail may not add to totals due to rounding. Excludes premium and per capita amounts and state expenditures not eligible for federal matching funds.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary, Medicaid Statistics Branch.

Table 4.3
Medicare Enrollments and Benefit Payments (000,000 omitted)

Calendar year	Hospital and/or medical insurance		Hospital insurance (Part A)		Supplementary medical insurance (Part B)	
	Number of enrolled persons*	Benefit payments	Number of enrolled persons*	Benefit payments	Number of enrolled persons*	Benefit payments
All Enrollees						
1966 (July-Dec.)	19.1	\$ 1,019	19.1	\$ 891	17.7	\$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.0	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973	23.5	9,583	23.3	7,057	22.5	2,526
1974	24.2	12,418	23.9	9,099	23.2	3,318
1975	25.0	15,588	24.6	11,315	23.9	4,273
1976	25.7	18,420	25.3	13,340	24.6	5,080
1977	26.5	21,773	26.1	15,735	25.4	6,038
1978	27.2	24,919	26.8	17,667	26.1	7,252
1979	27.9	29,313	27.5	20,605	26.8	8,708
1980	28.5	35,686	28.1	25,051	27.4	10,635
1981	29.0	43,442	28.6	30,329	27.9	13,113
1982	29.5	51,086	29.1	35,631	28.4	15,455
1983	30.0	57,443	29.6	39,337	29.0	18,106
1984	30.5	62,870	30.0	43,209	29.4	19,661
1985	31.1	70,391	30.6	47,444	30.0	22,947
Enrollees Age 65 and Over						
1966 (July-Dec.)	19.1	\$ 1,019	19.1	\$ 891	17.7	\$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.0	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973	21.8	9,192	21.6	6,803	20.9	2,389
1974	22.3	11,223	22.0	8,295	21.4	2,928
1975	22.8	13,994	22.5	10,250	21.9	3,744
1976	23.3	16,339	22.9	11,959	22.4	4,380
1977	23.8	19,178	23.5	14,012	23.0	5,166
1978	24.4	21,796	24.0	15,644	23.5	6,152
1979	24.9	25,472	24.5	18,144	24.1	7,328
1980	25.5	31,031	25.1	22,096	24.7	8,935
1981	26.0	37,793	25.6	26,785	25.2	11,008
1982	26.5	44,393	26.1	31,413	25.7	12,980
1983	27.1	50,152	26.7	34,761	26.3	15,391
1984	27.6	55,374	27.1	38,321	26.8	17,053
1985	28.2	62,185	27.7	42,074	27.3	20,111

*As of July 1.

NOTE: Some data have been revised. Detail may not add to totals due to rounding.

SOURCE: Department of Health and Human Services, Bureau of Data Management and Strategy, Health Care Financing Administration.

Table 4.4
Medicare and Medicaid Benefits by State, 1985

State	Medicare		Medicaid*	
	Benefits paid** (000,000)	Number of persons enrolled (000)	Benefits paid*** (000,000)	Unduplicated count of recipients (000)
Alabama	\$ 1,056	533	\$ 375	316
Alaska	40	18	66	24
Arizona	860	407	—	—
Arkansas	697	367	358	197
California	8,227	2,927	4,045	3,381
Colorado	657	303	316	147
Connecticut	988	436	595	217
Delaware	160	77	71	41
District of Columbia	285	79	298	98
Florida	4,828	2,000	943	562
Georgia	1,263	653	760	469
Hawaii	195	102	140	92
Idaho	199	117	76	39
Illinois	3,744	1,441	1,653	1,063
Indiana	1,367	696	747	284
Iowa	821	435	360	212
Kansas	752	342	256	142
Kentucky	875	493	540	408
Louisiana	977	474	725	416
Maine	353	169	232	124
Maryland	1,252	480	584	329
Massachusetts	2,226	824	1,433	523
Michigan	3,029	1,130	1,517	1,133
Minnesota	1,024	549	1,001	357
Mississippi	651	344	274	300
Missouri	1,639	737	525	356
Montana	199	106	96	47
Nebraska	441	227	167	94
Nevada	243	100	66	28
New Hampshire	247	124	118	38
New Jersey	2,625	1,024	1,145	581
New Mexico	292	150	148	87
New York	6,236	2,425	7,588	2,242
North Carolina	1,303	774	647	343
North Dakota	212	93	117	37
Ohio	3,137	1,408	1,767	1,045
Oklahoma	853	420	460	270
Oregon	762	374	239	153
Pennsylvania	4,662	1,822	1,797	1,071
Rhode Island	315	149	250	101
South Carolina	624	380	309	238
South Dakota	188	104	94	34
Tennessee	1,231	629	578	362
Texas	3,886	1,600	1,414	761
Utah	214	136	110	72
Vermont	138	69	89	50
Virginia	1,260	634	547	303
Washington	1,005	535	584	326
West Virginia	550	290	173	211
Wisconsin	1,371	664	942	473
Wyoming	88	45	28	20
State Unknown	14	22	—	—
United States	\$70,261	30,437	\$37,364	20,219
U.S. territories & possessions	248	402	143	1,588
Foreign countries	17	244	—	—
Grand total	\$70,527	31,083	\$37,507	21,808

*Medicaid figures are preliminary.

**Medicare data exclude retroactive adjustment made at end of accounting year on basis of reasonable costs of operation.

***Medicaid data for some states includes expenditures not computable for federal funding.

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

Table 4.5
Hospital and Medical Expenditures Under Workers'
Compensation (000,000 omitted)

Year	State and local	Federal	Total
1965	\$ 787	\$ 12	\$ 799
1966	897	13	910
1967	996	15	1,012
1968	1,130	17	1,147
1969	1,244	19	1,263
1970	1,384	25	1,409
1971	1,414	27	1,441
1972	1,545	30	1,575
1973	1,848	35	1,884
1974	2,133	43	2,176
1975	2,371	61	2,436
1976	2,685	73	2,758
1977	3,112	79	3,191
1978	3,585	97	3,682
1979	4,424	117	4,541
1980	5,012	140	5,151
1981	5,536	159	5,695
1982	5,898	200	6,098
1983	6,280	263	6,543
1984	6,846	297	7,142
1985	7,900	300	8,200

NOTE: For 1970 and succeeding years, data include federal "black lung" benefits. Detail may not add to totals due to rounding.

SOURCE: Health Care Financing Administration, *Health Care Financing Notes*, September 1986.

Table 4.6
Expenditures for Public Health Programs of State and Local Health Agencies, by Source of Funds, 1984 (000 omitted)

States and territories	Total public health expenditures	Federal grant and contract funds	State funds	Local funds	Fees, reimbursements, and other sources	Source unknown
Alabama	\$ 67,477	\$ 44,379	\$ 21,282	—	\$ 1,817	—
Alaska	29,530	5,740	23,791	—	—	—
Arizona	236,797	36,647	65,384	\$ 65,379	69,387	—
Arkansas	56,111	25,500	30,007	—	604	—
California	736,405	198,172	448,234	90,000	—	—
Colorado	90,397	45,281	23,342	17,302	4,472	—
Connecticut	73,313	30,710	27,638	14,679	286	—
Delaware	34,565	5,610	27,789	—	1,167	—
District of Columbia	92,909	35,337	57,572	—	—	—
Florida	247,022	69,221	98,208	32,823	46,770	—
Georgia	176,872	72,174	71,157	23,287	10,254	—
Hawaii	162,111	12,425	87,406	200	62,079	—
Idaho	29,244	12,621	9,512	3,350	3,762	—
Illinois	240,836	83,931	47,042	95,349	14,514	—
Indiana	85,656	39,545	22,359	—	—	\$ 23,752
Iowa	50,711	19,863	15,152	7,956	7,739	—
Kansas	46,824	19,666	12,894	9,600	4,664	—
Kentucky	221,537	52,748	103,526	15,647	49,616	—
Louisiana	113,882	63,089	33,762	8,060	8,971	—
Maine*	—	—	—	—	—	—
Maryland	466,933	57,977	355,885	38,181	13,890	1,000
Massachusetts*	—	—	—	—	—	—
Michigan	366,121	108,299	108,785	94,850	54,187	—
Minnesota	129,830	36,388	26,470	31,033	33,361	2,576
Mississippi	88,108	46,251	16,601	6,604	18,653	—
Missouri	113,146	53,204	23,495	26,612	9,835	—
Montana*	—	—	—	—	—	—
Nebraska	25,494	13,969	4,605	4,200	2,720	—
Nevada	25,743	9,512	6,462	5,299	4,470	—
New Hampshire	17,201	9,974	6,856	—	371	—
New Jersey	114,621	68,928	38,037	—	7,656	—
New Mexico*	—	—	—	—	—	—
New York	499,444	168,613	324,399	—	6,432	—
North Carolina	202,980	63,204	55,217	—	18,309	66,250
North Dakota	20,240	12,406	3,247	2,868	1,718	—
Ohio*	—	—	—	—	—	—
Oklahoma	93,811	30,534	38,239	17,596	7,442	—
Oregon	34,673	23,461	6,039	—	5,173	—
Pennsylvania	278,956	97,150	121,266	—	2,838	57,702
Rhode Island	27,832	10,842	16,991	—	—	—
South Carolina	136,095	55,232	57,898	2,209	20,755	—
South Dakota*	—	—	—	—	—	—
Tennessee	130,112	58,878	52,171	6,186	12,876	—
Texas	421,756	134,058	133,751	130,560	23,388	—
Utah	46,541	22,604	12,993	7,879	3,066	—
Vermont	18,083	11,764	5,719	—	600	—
Virginia	160,702	43,962	66,397	32,314	18,029	—
Washington	98,572	29,238	21,658	35,287	12,388	—
West Virginia	153,229	48,767	90,734	4,766	8,962	—
Wisconsin*	—	—	—	—	—	—
Wyoming	13,175	4,150	7,958	694	374	—
U.S. territories†	421,688	96,487	325,201	—	—	—
Grand total	\$6,897,286	\$2,188,511	\$3,153,130	\$830,772	\$573,594	\$151,280

*The Public Health Agencies in American Samoa, Guam, Maine, Montana, Massachusetts, New Mexico, Ohio, South Dakota, and Wisconsin did not report to the Public Health Foundation for FY 1984.

†U.S. territories include Puerto Rico and the Virgin Islands.

NOTE: The data in this table relate only to expenditures of official state health agencies. The public health expenditures of other agencies such as separate mental health authorities, environmental agencies, and hospital authorities are not reflected in the Public Health Foundation's data base.

SOURCE: Public Health Foundation, 1220 L Street, N.W., Suite 350, Washington, D.C. 20005.



Chapter 5

Medical Care Costs

Each year Americans spend more money for medical care. The increases result from a combination of factors—higher costs, greater demand for health services, rising incomes, and growth and availability of private health insurance. Other major influences include the introduction of newer and costlier medical techniques and procedures, higher educational level of the population (which is generally associated with greater expenditures for personal health care), growing awareness of the availability of medical care, and a rising proportion of elderly persons in the population, who, as a group, are prone to a higher incidence of health-related problems.

Total Medical Expenditures

In this chapter, spending for health care is discussed in terms of National Health Expenditures, Personal Health Care Expenditures, Personal Consumption Expenditures for Medical Care, the Consumer Price Index.

National Health Expenditures

Total health care spending, represented by the **National Health Expenditure (NHE)** figure, includes both private and public expenditures for personal health care, medical research and construction of medical facilities, administrative and health insurance costs, and government-spon-

sored public health activities. Because of its all-inclusive nature, the National Health Expenditure will be discussed in terms of, and compared to, the Gross National Product. The National Health Expenditure figure covers spending for health care over the 12-month calendar year.

National health spending reached \$425.0 billion in 1985 (Table 5.1), or an average of \$1,721 per person.

Total health expenditures showed an 8.9% increase in 1985, compared with a 9.2% increase in 1984. Public spending, which financed 40.9% of all health care costs in 1984, increased to 41.1% of the total in 1985, and private spending rose 8.5%.

In 1965, National Health Expenditures constituted 5.9% of the Gross National Product. This proportion has continued to increase over the years, reaching 10.6% in 1985.

Hospital care continued to represent the largest share of spending for health care, totaling \$166.7 billion in 1985. The cost of physicians' services was the next highest at \$82.8 billion.

According to projections made by the Health Care Financing Administration, National Health Expenditures are estimated to reach \$454.2 billion in 1986, and \$639.6 billion by 1990. Per capita expenditures were \$1,721 in 1985, almost 8% more than the 1984 figure of \$1,595. By 1990, per capita expenditures are expected to be \$2,551.

Personal Health Care Expenditures

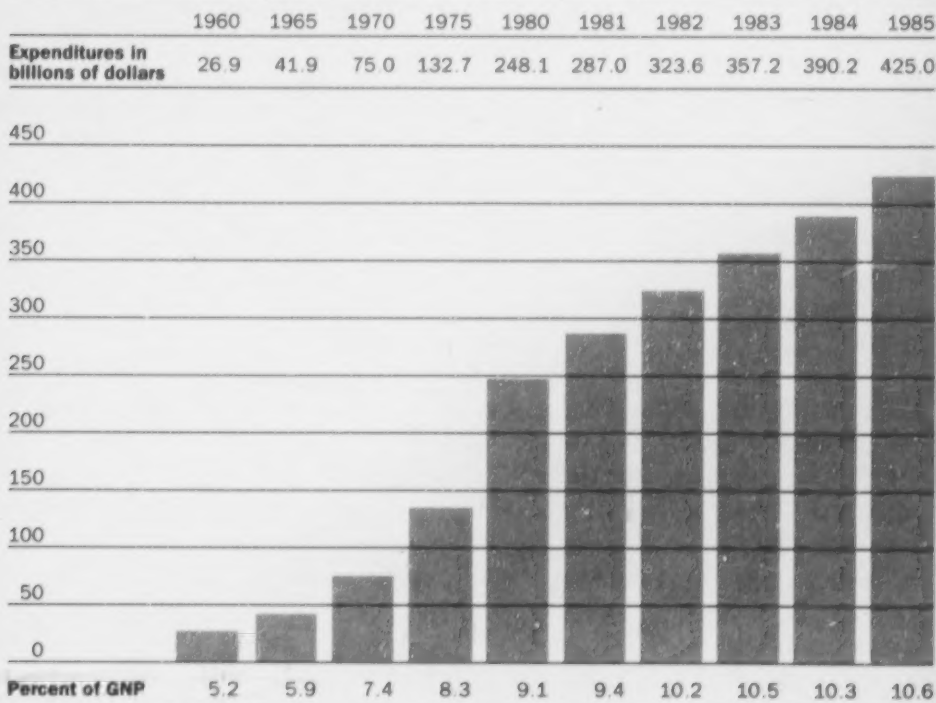
The **Personal Health Care Expenditure (PHCE)** figure represents private and public spending for health and medical services for the direct benefit of the individual, representing 87.4% of 1985 National Health Expenditures.

Spending for personal health care in the nation amounted to \$371.4 billion in 1985 (Table 5.4). This sum includes all outlays for health and medical services for the direct benefit of the individual, including both public and private spending.

Included are expenditures for hospital care, physicians', dentists' and other professional services, drugs and medical sundries, eyeglasses and appliances, nursing home care, and spending for in-plant health services. Not included are expenditures for medical research, construction of medical facilities, public health activities such as disease prevention and control, and the net cost of health insurance — the difference between premiums and benefits paid. (The latter items are included in the National Health Expenditure figure.)

Table 5.5 shows per capita amount

National Health Expenditures and Percent of Gross National Product



of personal expenditure by age group and type of expenditure for 1984. These provisional estimates by the Health Care Financing Administration indicate Americans of all ages spent a per capita amount of \$635 for hospital care and \$308 for physicians' services. For Americans 65 years of age and over, the per capita expenditure was \$1,900 for hospital care, \$868 for physicians' services and \$880 for nursing home care.

According to the Health Care Financing Administration, U.S. nursing home expenses in 1985 came to \$35.2 billion of which Medicare contributed only \$600 million. Medicaid paid nearly half (\$14.7 billion) making it a de facto long-term care financing program. The remaining cost of financing long-term care fell almost exclusively on the patients and their families (\$18.1 billion). Private long-term care insurance, still in its infancy, covered only \$3 million.

The largest portion of the personal health care dollar is financed by third-party sources (Table 5.8). Private health insurance, philanthropy, industry and the government paid 72% of all expenditures for personal health care in 1985.

Personal health care figures include expenditures of all consumers, whether insured or not. Included are expenses for non-prescribed drugs and medicines, household supplies such as tissues and rubbing alcohol, and other items not covered by insurance.

In terms of the growth of personal health care components, hospital care has been the fastest growing category of expenditures. In 1970, monies spent for hospital care represented 43% of personal health care expenses. In 1985, the proportion was 45%.

Personal Consumption Expenditures

Personal Consumption Expenditures (PCE) for medical care represent private payments, although monies from three government programs (Medicare, Workers' Compensation and Temporary Disability Insurance) are treated as transfer payments and are included. The PCE is computed as an annual average.

While the same basic categories of expenditures constitute the PCE for medical care and the PHCE portion of the NHE figure, different accounting practices are used for each. Some important distinctions include:

(1) With respect to hospital costs, the PHCE figure focuses on personal outlays for hospital services and does not include the cost of providing services; the PCE includes the latter item for private, nonprofit hospitals.

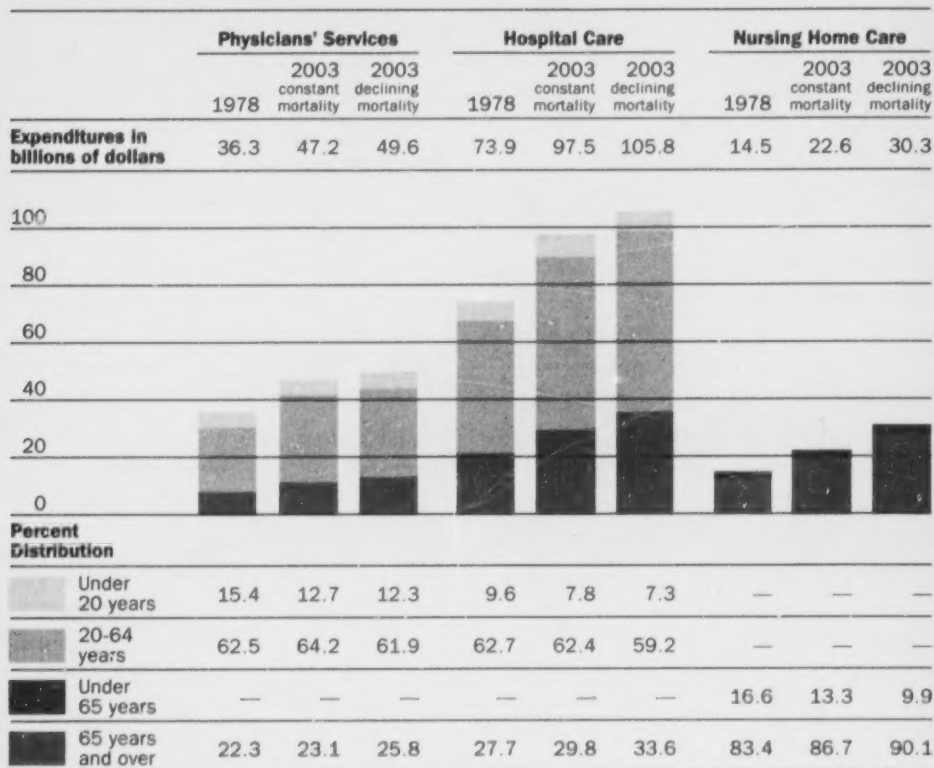
(2) The PCE includes the net cost of health insurance (i.e., earned premiums less benefits paid) but the PHCE does not. However, this figure is included in the NHE data.

Personal Consumption Expenditures for medical care were \$323.5 billion for 1985 (Table 5.9), almost three and one-half times the amount spent 10 years earlier. The 1985 amount represented 12.4% of the total spent by Americans on all personal needs, compared with 9.6% a decade earlier.

As a proportion of the public's disposable personal income, these expenditures were 11.4% in 1985, up from 8.5% in 1975 (Table 5.10).

Personal Consumption Expenditures for nongovernmental hospital care (including expenses of nonprofit hospitals, sanitariums and nursing homes, and payments by patients to proprietary

Projected Expenditures for Physicians' Services, Hospital Care, and Nursing Home Care, and Percent Distribution by Age: United States, 1978 and 2003



SOURCE: U.S. Department of Health and Human Services, *Changing Mortality Patterns, Health Services Utilization, and Health Care Expenditures: United States 1978-2003*.

hospitals, sanitariums and nursing homes) were \$138.4 billion in 1985 (Table 5.11), three and one half times the amount in 1975. Payments for physicians' services were \$73.3 billion, three times the amount spent a decade earlier.

Consumer Price Index

The Consumer Price Index (CPI) measures the average change in prices of all types of consumer goods and services purchased by urban wage earners and clerical workers. The index measures the effect of *price change only* on the cost of living. It

does *not* measure changes in the total amount families spend.

According to the Consumer Price Index (CPI), in 1986, medical costs increased by 7.5% over 1985, compared to a 1.9% increase for all items (Table 5.13).

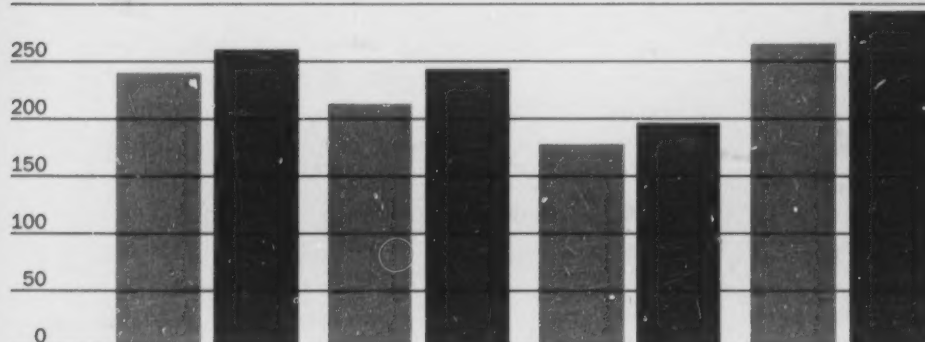
Individual components of medical care have differed in their rate of increase. Hospital room rates have risen most rapidly.

Hospital Charges

Community Hospital Statistics. The average cost to community hospitals to treat a person in 1985 was \$460.19

Average Cost to Patient Per Day for Semiprivate Hospital Room, by Region

	Northeast		Midwest		South		West	
	Jan. 1986	Jan. 1987	Jan. 1986	Jan. 1987	Jan. 1986	Jan. 1987	Jan. 1986	Jan. 1987
Dollars	241.00	260.83	212.16	242.38	179.60	195.02	265.54	293.34



NOTE: Northeast includes New England and Middle Atlantic states; Midwest, East North Central and West North Central states; South, South Atlantic, East South Central and West South Central states; and West, Mountain and Pacific states. Data exclude Puerto Rico.

SOURCE: Health Insurance Association of America, *Survey of Hospital Semi-Private Room Charges*, as of January 1987.

per inpatient-day, an 11.9% increase over 1984. On a state-by-state basis, the average cost per day in 1985 varied considerably from a low of \$282.05 in South Dakota to a high of \$693.44 in Alaska.

In 1985, the average length of time a patient remained in a community hospital was 7.1 days, down from 7.6 days just two years earlier.

Although the length of the average hospital stay has declined 6.6% since 1983, the cost for the average stay increased 16% to reach \$3,244.74 in 1985.

The average length of stay varied by area, from a low of 5.1 days in Utah to a high of 9.4 days in New York. Differences reflect the incidence of various diseases, age distribution of the population, income levels and postponement of nonemergency admissions.

Operating costs of community hospi-

tals increased to \$130.5 billion in 1985, 235% more than the \$39.0 billion in 1975, and 70% higher than in 1980.

The American Hospital Association reports that payrolls reached \$60.4 billion, representing 46.3% of community hospital expenditures in 1985.

Semiprivate Room Charges. A continuing survey conducted by the Health Insurance Association of America shows that as of January 1987, the national average daily cost to the patient for a semiprivate room was \$243.90, a 7.5% increase over January 1986 (Table 5.17). Survey results are based on responses from 2,802 nongovernmental short-term general hospitals nationwide. The highest average rate was in the West, at \$293.34 per day. The lowest average rate was in the South, at \$195.02 per day.

Professional Fees

Surgical and Dental Charges. Surgical charges vary considerably by geographic region and by metropolitan and nonmetropolitan areas. Table 5.18, containing data from a 1986 survey by *Medical Economics* magazine, shows the variance of some common surgical procedures and emergency medical procedures across the United States.

Results of a 1985 survey of average dental charges by the American Dental Association (Table 5.19), show variation by geographic region.

Physician Fees. Tables 5.20 and 5.21 show physician fees vary considerably by type of practice or speciality, type of visit and region of the United States. In 1986, the median charges for an initial office visit and an office revisit were highest for specialists and for physicians practicing in the Western states.

Cost of Having a Baby

In 1986 the Health Insurance Association of America conducted a national survey to determine the medical

costs incurred in having a baby. As shown in Table 5.22, the total cost of a usual delivery in a hospital delivery room averaged \$2,560, according to the 1986 survey. This was a 25% increase over the \$2,047 that was reported in January 1982. Cost differences are more marked between metropolitan and nonmetropolitan areas than among the four regions of the United States. The total costs for a usual birth varied from \$2,120 (birthing room) in the nonmetropolitan Midwest to \$3,090 (labor and delivery room) in the metropolitan West. The total medical costs for an uncomplicated cesarean, the procedure by which nearly one in five women had their babies in 1985, average \$4,270 in the United States.

Medical Costs Resulting from Accidents

The economic losses that result from various types of accidents are shown in Table 5.23. Medical expense costs incurred through accidents totaled \$17.8 billion in 1985.

Table 5.1
National Health Expenditures, by Type of Expenditure and Source of Funds, 1985 (000,000,000 omitted)

Type of Expenditure	Total	Private	Public
Personal health care	\$371.4	\$224.0	\$147.5
Program administration and net cost of insurance	26.2	20.4	5.8
Government public health activities	11.9	—	11.9
Research	7.4	0.4	7.0
Construction	8.1	5.5	2.6
Total	\$425.0	\$250.2	\$174.8

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Notes*, September 1986.

Table 5.2
Comparison of Growth Rates of Gross National Product and National Health Expenditures

Calendar year	Gross National Product		National Health Expenditures		NHE as percent of GNP
	Amount (000,000,000)	Annual rate of growth	Amount (000,000,000)	Annualized percentage change	
1950	\$ 288.3	10.7%	\$ 12.7	12.2%	4.4%
1955	405.9	9.0	17.7	7.0	4.4
1960	515.3	3.9	26.9	8.7	5.2
1965	705.1	8.5	41.9	9.2	5.9
1970	1,015.5	5.3	75.0	14.3	7.4
1971	1,102.7	8.6	83.5	11.3	7.6
1972	1,212.8	10.0	94.0	12.6	7.8
1973	1,359.3	12.1	103.4	10.0	7.6
1974	1,472.8	8.3	116.1	12.3	7.9
1975	1,598.4	8.5	132.7	14.3	8.3
1976	1,782.8	11.5	150.8	13.6	8.5
1977	1,990.5	11.7	169.9	12.7	8.5
1978	2,249.7	13.0	189.7	11.7	8.4
1979	2,508.2	11.5	214.7	13.2	8.6
1980	2,732.0	8.9	248.1	15.6	9.1
1981	3,052.6	11.7	287.0	15.7	9.4
1982	3,166.0	3.7	323.6	12.8	10.2
1983	3,405.7	7.6	357.2	10.4	10.5
1984	3,772.2	10.7	390.2	9.2	10.3
1985	4,010.3	6.3	425.0	8.9	10.6

NOTE: Some data are revised from previous editions.

SOURCES: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Notes*, September 1986 and unpublished data from the U.S. Department of Commerce.

Table 5.3
National Health Expenditure by Type of Expenditure
 (000,000,000 omitted)

Type of expenditure	1970	1975	1980	1983	1984	1985
Total	\$75.0	\$132.7	\$248.1	\$357.2	\$390.2	\$425.0
Health services and supplies	69.6	124.3	236.2	341.8	374.5	409.5
Personal health care expenses	65.4	117.1	219.7	314.7	341.1	371.4
Hospital care	28.0	52.4	101.6	146.8	155.3	166.7
Physicians' services	14.3	24.9	46.8	68.4	75.4	82.8
Dentists' services	4.7	8.2	15.4	21.7	24.6	27.1
Other professional services	1.6	2.6	5.7	9.3	10.9	12.6
Drugs and medical sundries	8.0	11.9	18.8	24.5	26.5	28.5
Eyeglasses and appliances	1.9	3.2	5.1	6.2	7.0	7.5
Nursing home care	4.7	10.1	20.4	29.4	31.9	35.2
Other health services	2.1	3.8	5.9	8.3	9.4	11.0
Program administration and net cost of insurance	2.8	4.0	9.2	17.1	22.6	26.2
Government public health activities	1.4	3.2	7.3	9.9	10.9	11.9
Research and medical facilities construction	5.4	8.4	11.9	15.4	15.6	15.4
Research	2.0	3.3	5.4	6.2	6.8	7.4
Construction	3.4	5.1	6.5	9.2	8.9	8.1

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Notes*, September 1986.

Table 5.4
National Health Care Expenditures
by Type of Expenditure and Source of Funds
 (000,000,000 omitted)

Year and type of expenditure	All sources	Private				Government	
		Total	Direct	Consumer	Other*	Federal	State and local
				Private insurance			
1985							
National health expenditures	\$425.0	\$238.9	\$105.6	\$133.3	\$11.3	\$124.4	\$50.4
Health services and supplies	409.5	238.9	105.6	133.3	5.4	117.2	48.0
Personal health care	371.4	219.1	105.6	113.5	4.9	112.6	34.8
Hospital care	166.7	74.8	15.6	59.3	2.1	71.6	18.2
Physicians' services	82.8	58.7	21.8	36.8	**	19.7	4.4
Dentists' services	27.1	26.5	17.2	9.3	—	0.3	0.3
Other professional services	12.6	8.8	6.0	2.8	0.1	2.8	0.9
Drugs and medical sundries	28.5	25.8	21.7	4.0	—	1.4	1.3
Eyeglasses and appliances	7.5	6.1	5.2	0.9	—	1.3	0.1
Nursing home care	35.2	18.4	18.1	0.3	0.3	9.4	7.1
Other personal health care	11.0	—	—	—	2.3	6.0	2.6
Program administration and net cost of private health insurance	26.2	19.8	—	19.8	0.6	3.2	2.7
Government public health activities	11.9	—	—	—	—	1.4	10.5
Research and construction of medical facilities	15.4	—	—	—	5.9	7.2	2.4
Noncommercial research	7.4	—	—	—	0.4	6.4	0.6
Construction	8.1	—	—	—	5.5	0.8	1.8
1984							
National health expenditures	\$390.2	\$219.3	\$ 97.8	\$121.5	\$11.4	\$111.7	\$47.8
Health services and supplies	374.5	219.3	97.8	121.5	4.9	105.1	45.3
Personal health care	341.1	202.7	97.8	104.9	4.3	100.9	33.2
Hospital care	155.3	70.6	14.3	56.4	1.9	65.3	17.5
Physicians' services	75.4	54.2	20.9	33.3	**	17.0	4.1
Dentists' services	24.6	24.1	15.9	8.2	—	0.3	0.3
Other professional services	10.9	7.7	5.3	2.4	0.1	2.4	0.8
Drugs and medical sundries	26.5	24.2	20.6	3.6	—	1.2	1.2
Eyeglasses and appliances	7.0	5.7	5.0	0.8	—	1.1	0.1
Nursing home care	31.9	16.1	15.8	0.3	0.2	8.6	6.9
Other personal health care	9.4	—	—	—	2.0	5.1	2.3
Program administration and net cost of private health insurance	22.6	16.6	—	16.6	0.5	2.9	2.6
Government public health activities	10.9	—	—	—	—	1.4	9.5
Research and construction of medical facilities	15.6	—	—	—	6.6	6.5	2.5
Noncommercial research	6.8	—	—	—	0.4	5.8	0.6
Construction	8.9	—	—	—	6.2	0.7	1.9

*Includes spending by philanthropic organizations, industrial implant health services and privately financed construction.

**Less than \$50,000,000.

SOURCE: Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimates.

Table 5.5
Per Capita Amount of Personal Expenditures
By Age and Type of Expenditure, 1984

Type of Expenditure	Per Capita Amount					
	All ages			Age 65 and over		
	Total	Private	Public	Total	Private	Public
Hospital care	\$ 635	\$296	\$338	\$1,900	\$216	\$1,684
Physicians' services	308	221	86	868	344	524
Nursing home care	130	67	63	880	457	423
Other health services	321	261	60	554	362	192
Total	\$1,394	\$847	\$548	\$4,202	\$1,379	\$2,823

Note: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health & Human Services, Health Care Financing Administration, *Health Care Financing Notes*, and unpublished data, September 1986.

Table 5.6
Factors Affecting Growth of Personal Health Care
Expenditures: Twelve Month Period Ending December

	1981	1982	1983	1984	1985
All factors	100%	100%	100%	100%	100%
Prices	72	78	70	75	63
Population	6	8	11	11	11
Intensity	22	14	19	14	26

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Notes*, September 1986.

Table 5.7
Personal Health Care Expenditures by Type of Payer and
Type of Expenditure, 1985 (000,000,000 omitted)

Source of payment	Total personal care	Hospital care	Physicians' services	Nursing home care	Other health services
Personal health care expenditures	\$371.4	\$166.7	\$82.8	\$35.2	\$86.7
Direct payments	105.6	15.6	21.8	18.1	50.1
Third party payments	265.8	151.2	61.0	17.1	36.5
Private health insurance	113.5	59.3	36.8	0.3	17.0
Other private Funds	4.9	2.1	*	0.3	2.4
Government	147.5	89.8	24.1	16.5	17.0
Medicare	70.5	48.5	17.1	0.6	4.4
Medicaid	39.8	14.8	3.4	14.7	6.8
Other	37.2	26.5	3.6	1.2	5.8

*Less than \$50,000,000.

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Notes*, September 1986.

Table 5.8
Personal Health Care Expenditures by Source of Payment

Year	Total	Direct patient payments	All third parties	Private health insurance	Other private funds	Third parties				
						Total	State and local	Government		
								Total*	Medicare	Medicaid
Amount in billions										
1965	\$ 35.9	\$ 18.5	\$ 17.3	\$ 8.7	\$ 0.8	\$ 7.9	\$ 4.3	\$ 3.6	—	—
1966	39.7	19.6	20.0	9.1	0.8	10.1	4.9	5.3	\$ 1.0	\$ 1.5
1967	44.5	19.0	25.5	9.6	0.8	15.1	5.6	9.5	4.5	2.9
1968	50.3	20.7	29.6	10.9	0.9	17.8	6.4	11.4	5.7	3.8
1969	57.1	23.0	34.0	12.9	0.9	20.2	7.0	13.2	6.6	4.4
1970	65.4	26.5	38.9	15.3	1.1	22.4	7.9	14.5	7.1	5.2
1971	72.2	28.1	44.1	17.2	1.3	25.6	8.8	16.8	7.9	6.8
1972	80.5	30.6	49.9	19.0	2.0	28.8	9.9	18.9	8.6	8.2
1973	89.0	33.3	55.7	21.4	2.2	32.1	11.1	21.1	9.6	9.3
1974	101.3	36.2	65.1	25.1	1.5	38.5	12.8	25.7	12.4	10.8
1975	117.1	38.1	79.0	31.2	1.6	46.3	14.9	31.4	15.6	13.5
1976	132.8	42.0	90.8	37.6	1.8	51.4	15.3	36.1	18.4	15.1
1977	149.1	46.4	102.7	43.0	2.0	57.8	16.8	40.9	21.8	16.9
1978	167.4	50.7	116.7	49.1	2.1	65.5	19.2	46.3	24.9	18.8
1979	189.7	55.8	133.8	56.9	2.3	74.6	21.3	53.3	29.3	21.8
1980	219.7	63.0	156.7	67.5	2.7	86.5	24.0	62.5	35.7	25.2
1981	254.7	72.6	182.1	78.4	3.2	100.5	26.3	74.1	43.5	29.0
1982	286.5	79.6	206.9	89.9	3.5	113.5	29.5	83.9	51.1	31.3
1983	314.7	88.7	226.0	98.0	4.0	124.1	31.1	92.9	57.4	33.9
1984	341.1	97.8	243.3	104.9	4.3	134.1	33.2	100.9	62.9	36.3
1985	371.4	105.6	265.8	113.5	4.9	147.5	34.8	112.6	70.5	39.8
Per capita amount*										
1965	\$ 176	\$ 91	\$ 85	\$ 42	\$ 4	\$ 39	\$ 21	\$ 18	N.A.	N.A.
1966	192	95	97	44	4	49	24	25	N.A.	N.A.
1967	213	91	122	46	4	72	27	45	N.A.	N.A.
1968	239	98	140	52	4	84	30	54	N.A.	N.A.
1969	268	108	160	61	4	95	33	62	N.A.	N.A.
1970	304	123	181	71	5	104	37	68	N.A.	N.A.
1971	332	129	203	79	6	118	41	77	N.A.	N.A.
1972	367	140	227	87	9	131	45	86	N.A.	N.A.
1973	402	150	252	97	10	145	50	95	N.A.	N.A.
1974	454	162	292	113	7	173	57	115	N.A.	N.A.
1975	521	169	351	139	7	206	66	140	N.A.	N.A.
1976	586	185	400	166	8	227	67	159	N.A.	N.A.
1977	652	203	449	188	9	253	74	179	N.A.	N.A.
1978	725	220	506	213	9	284	83	201	N.A.	N.A.
1979	814	240	574	244	10	320	91	229	N.A.	N.A.
1980	934	268	666	287	11	367	102	266	N.A.	N.A.
1981	1,071	305	766	330	13	423	111	312	N.A.	N.A.
1982	1,193	332	861	374	15	472	123	349	N.A.	N.A.
1983	1,298	366	932	404	16	512	128	383	N.A.	N.A.
1984	1,394	400	994	429	18	548	136	412	N.A.	N.A.
1985	1,504	428	1,076	460	20	597	141	456	N.A.	N.A.

N.A. — Not available.

*Includes funds not identified separately.

NOTE: Some data are revised.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Notes*, September 1986.

Table 5.9
Personal Consumption Expenditures by Type of Product,
United States, 1985

Type of Product	Personal consumption expenditures (000,000,000 omitted)	Percent of total
Food (including alcohol)	\$ 469.4	18.1%
Housing	403.9	15.5
Household operation	349.8	13.5
Transportation	329.3	12.7
Medical care*	323.5	12.4
Clothing, accessories and jewelry	192.2	7.4
Recreation	176.3	6.8
Personal business	167.7	6.5
Private education and research	56.1	2.1
Religious and welfare activities	41.9	1.6
Tobacco	38.6	1.5
Personal care	31.8	1.2
Foreign travel and remittances—net	13.8	0.5
Funeral and burial expenses	6.2	0.2
Total	\$2,600.5	100.0%

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U. S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, July 1986, and Health Insurance Association of America.

Table 5.10

Ratio of Personal Consumption Expenditures for Medical Care to Disposable Personal Income and to Total Personal Consumption Expenditures in the United States

(000,000,000 omitted)

(1)	(2)	(3)	(4)	(5)	(6)
Calendar year	Personal consumption expenditures for medical care*	Disposable personal income	Total personal consumption expenditures	Ratio of col. (2) to col. (3)	Ratio of col. (2) to col. (4)
1950	\$ 8.8	\$ 207.5	\$ 192.1	4.3%	4.6%
1955	13.4	278.8	257.9	4.8	5.2
1960	20.6	358.9	330.7	5.7	6.2
1965	31.6	486.8	440.7	6.5	7.2
1966	34.3	525.9	477.3	6.5	7.2
1967	37.1	562.1	503.6	6.6	7.4
1968	42.5	609.6	552.5	7.0	7.7
1969	48.3	656.7	597.9	7.4	8.1
1970	55.0	715.6	640.0	7.7	8.6
1971	60.9	776.8	691.6	7.8	8.8
1972	67.6	839.6	757.6	8.1	9.0
1973	75.1	949.8	837.2	7.9	9.0
1974	84.3	1,038.3	916.5	8.1	9.2
1975	96.9	1,142.8	1,012.8	8.5	9.6
1976	109.9	1,252.6	1,129.3	8.8	9.7
1977	126.5	1,379.3	1,257.2	9.2	10.1
1978	141.0	1,151.2	1,403.5	12.2	10.0
1979	160.6	1,729.3	1,566.8	9.3	10.3
1980	185.7	1,917.9	1,732.6	9.7	10.7
1981	217.3	2,127.6	1,915.1	10.2	11.3
1982	242.7	2,261.4	2,050.7	10.7	11.8
1983	266.5	2,428.1	2,234.5	11.0	11.9
1984	294.1	2,668.6	2,428.2	11.0	12.1
1985	323.5	2,841.1	2,600.5	11.4	12.4

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (various issues) and Health Insurance Association of America.

Table 5.11
Personal Consumption Expenditures for Medical Care in the
United States (000,000,000 omitted)

Calendar year	Total medical care	Hospital services	Physicians' services	Medicines and appliances	Dentists' services	Net cost of health insurance	All other medical care
1950	\$ 8.8	\$ 2.1	\$ 2.6	\$ 2.2	\$ 1.0	\$0.3	\$ 0.8
1955	13.4	3.4	3.8	3.0	1.5	0.6	1.1
1960	20.6	5.6	5.8	4.7	2.0	0.8	1.8
1965	31.6	8.9	8.5	6.4	2.8	1.3	3.7
1966	34.3	10.1	9.1	6.7	3.0	1.4	4.0
1967	37.1	11.8	10.0	7.0	3.4	1.3	3.7
1968	42.5	14.1	10.9	7.8	3.7	2.0	4.1
1969	48.3	17.0	12.4	8.6	4.3	1.9	4.1
1970	55.0	19.7	14.0	10.0	4.9	2.1	4.3
1971	60.9	23.2	15.3	10.5	5.1	2.6	4.2
1972	67.6	25.9	16.6	11.5	5.6	3.5	4.5
1973	75.1	28.8	18.4	12.5	6.6	3.6	5.2
1974	84.3	33.7	20.3	13.6	7.3	3.6	5.8
1975	96.9	40.1	23.5	14.9	8.2	3.2	7.0
1976	109.9	46.6	25.8	16.3	9.3	3.6	8.4
1977	126.5	53.3	29.6	17.4	10.3	5.4	10.4
1978	141.0	61.0	32.3	19.2	11.3	4.7	12.4
1979	160.6	70.0	36.3	21.6	12.3	5.6	14.8
1980	185.7	82.0	42.0	23.5	13.7	6.9	17.6
1981	217.3	96.8	49.0	25.8	16.1	7.6	22.0
1982	242.7	110.3	54.4	27.6	17.4	8.8	24.1
1983	266.5	119.6	61.1	30.3	18.5	11.0	25.8
1984	294.1	129.9	67.1	33.3	19.8	14.1	29.9
1985	323.5	138.4	73.3	35.8	21.3	18.6	36.1

NOTE: Some data are revised. The data exclude private expenditures in federal, state, city and other government hospitals and nursing homes. In some cases the sum of the items does not equal the "Total medical care" shown because of rounding.

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, various issues.

Table 5.12
Consumer Price Index for Medical Care Items in the United States (Annual Average, 1967 = 100.0)

Calendar year	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and prescriptions	
					Prescription drugs	Over-the-counter drugs
Urban wage and clerical workers						
1947	48.1	51.4	56.9	23.1	N.A.	N.A.
1950	53.7	55.2	63.9	30.3	92.6	N.A.
1955	64.8	65.4	73.0	42.3	101.6	N.A.
1960	79.1	77.0	82.1	57.3	115.3	N.A.
1965	89.5	88.3	92.2	75.9	102.0	N.A.
1966	93.4	93.4	95.2	83.5	101.8	N.A.
All urban consumers						
1967	100.0	100.5	100.4	101.2	99.9	100.2
1968	106.0	106.1	105.9	114.8	98.2	102.7
1969	113.4	112.9	112.9	128.8	99.5	103.4
1970	120.6	121.4	119.3	145.4	101.2	106.2
1971	128.4	129.8	127.0	163.1	101.3	110.2
1972	132.5	133.8	132.3	173.9	100.9	111.3
1973	137.7	138.2	136.4	182.1	100.5	112.4
1974	150.5	150.9	146.8	201.5	102.9	117.5
1975	168.6	169.4	161.9	236.1	109.3	130.1
1976	184.7	188.5	172.2	268.6	115.2	138.9
1977	202.4	206.0	185.1	299.5	122.1	148.5
1978	219.4	223.1	198.1	332.4	131.6	159.0
1979	239.7	243.6	214.8	370.3	141.8	170.7
1980	265.9	269.3	240.2	418.9	154.8	188.1
1981	294.5	299.0	263.3	481.1	172.5	211.4
1982	328.7	327.1	283.6	556.7	192.7	234.2
1983	357.3	352.3	302.7	619.7	213.8	251.7
1984	379.5	376.8	327.3	670.9	234.3	267.3
1985	403.1	398.8	347.9	710.5	256.5	281.7
1986	433.5	427.7	367.3	753.1	278.6	295.5

N.A.—Not Available.

NOTE: Some data are revised.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*, various issues.

Table 5.13
Annual Changes in Consumer Price Index

Calendar year	All items	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and prescriptions	
						Prescription drugs	Over-the-counter drugs
Urban wage and clerical workers							
1947	14.4%	8.3%	6.4%	8.4%	17.3%	9.9%	—
1950	11.0	1.9	1.5	2.4	3.4	2.7	—
1955	-0.4	2.2	3.5	1.0	4.2	1.4	—
1960	1.6	3.5	2.5	2.0	6.9	-0.3	—
1965	1.7	2.5	3.6	3.1	5.6	-1.1	—
1966	2.9	4.4	5.8	3.3	10.0	-0.2	—
All urban consumers							
1967	2.9	7.1	7.6	5.5	21.2	-1.7	—
1968	4.2	6.1	5.6	5.1	13.4	-1.6	2.5%
1969	5.4	6.9	6.4	7.0	13.4	1.3	0.7
1970	5.9	6.3	7.5	5.8	12.9	1.6	2.7
1971	4.3	6.5	6.9	6.4	12.2	0.1	3.8
1972	3.3	3.2	3.1	4.2	6.6	-0.4	1.0
1973	6.2	3.9	3.3	3.1	4.7	-0.4	1.0
1974	11.0	9.3	9.2	7.6	10.7	2.4	4.5
1975	9.1	12.0	12.3	10.3	17.2	6.2	10.7
1976	5.8	9.5	11.3	6.4	13.8	5.4	6.8
1977	6.5	9.6	9.3	7.5	11.5	6.0	6.9
1978	7.6	8.4	8.3	7.0	11.0	7.8	7.1
1979	11.3	9.3	9.2	8.4	11.4	7.7	7.4
1980	13.5	10.9	10.6	11.8	13.1	9.2	10.2
1981	10.4	10.8	11.0	9.6	14.9	11.5	12.4
1982	6.2	11.6	9.4	7.7	15.7	11.7	10.8
1983	3.2	8.7	7.7	6.7	11.3	11.0	7.5
1984	4.3	6.2	6.9	8.1	8.3	9.6	6.2
1985	3.6	6.2	5.8	6.3	5.9	9.5	5.4
1986	1.9	7.5	7.3	5.6	6.0	8.6	4.9

NOTE: Some data are revised.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*, various issues.

Table 5.14
Consumer Price Index in the United States
 (Annual Average, 1967 = 100.0)

Calendar year	All items	Food	Apparel	Housing	Transportation	Medical care	Entertainment	Other goods and services
Urban wage and clerical workers								
1935	41.1	36.5	40.8	49.3	42.6	36.1	41.8	44.6
1940	42.0	35.2	42.8	52.4	42.7	36.8	46.1	48.3
1945	53.9	50.7	61.5	59.1	47.8	42.1	62.4	56.9
1950	72.1	74.5	79.0	72.8	68.2	53.7	74.4	60.9
1955	80.2	81.6	84.1	82.3	77.4	64.8	76.7	79.8
1960	88.7	88.0	89.6	90.2	89.6	79.1	87.3	87.8
1965	94.5	94.4	93.7	94.9	95.9	89.5	95.9	94.2
1966	97.2	99.1	96.1	97.2	97.2	93.4	97.5	97.2
All urban consumers								
1967	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1968	104.2	103.6	105.4	104.0	103.2	106.1	105.7	105.2
1969	109.8	108.9	111.5	110.4	107.1	113.4	110.9	110.4
1970	116.3	114.9	116.1	118.1	112.7	120.6	116.7	116.8
1971	121.3	118.4	119.8	123.4	118.6	128.4	122.9	122.4
1972	125.3	123.5	122.3	128.2	119.9	132.5	126.5	127.5
1973	133.1	141.4	126.8	133.7	123.8	137.7	130.0	132.5
1974	147.7	161.7	136.2	148.8	137.7	150.5	139.8	142.0
1975	161.2	175.4	142.3	164.4	150.6	168.6	152.2	153.9
1976	170.5	180.8	147.6	174.5	165.5	184.7	159.8	162.7
1977	181.5	192.2	154.2	186.5	177.2	202.4	167.7	172.2
1978	195.4	211.4	159.6	202.8	185.5	219.4	176.6	183.3
1979	217.5	234.5	166.6	227.6	212.0	239.7	188.5	196.7
1980	246.8	254.6	178.4	263.2	249.7	265.9	205.3	214.5
1981	272.4	274.6	186.9	293.4	280.0	294.5	221.4	235.7
1982	289.2	285.7	191.8	314.6	291.5	328.7	235.8	259.9
1983	298.4	291.7	196.5	322.9	298.4	357.3	246.0	288.3
1984	311.2	302.9	200.2	336.3	311.7	379.5	255.1	307.7
1985	322.2	309.8	206.0	349.6	319.9	403.1	265.0	326.6
1986	328.4	319.7	207.8	360.0	307.5	433.5	274.1	346.4

NOTE: Some data are revised.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*, various issues.

Table 5.15
Average Cost to Community Hospitals Per Patient Day and
Per Patient Admission; Average Length of Stay in Community
Hospitals in the United States

Calendar year	Average cost to hospital per adjusted inpatient day*			Average length of hospital stay (days)	Average cost to hospital per adjusted admission*
	Total	Payroll	Other		
1946	\$ 9.39	\$ 4.98	\$ 4.41	9.1	\$ 85.45
1950	15.62	8.86	6.76	8.1	126.52
1955	23.12	14.26	8.86	7.8	180.34
1960	32.23	20.08	12.15	7.6	244.95
1961	34.98	21.54	13.44	7.6	265.85
1962	36.83	22.79	14.04	7.6	279.91
1963	38.91	24.01	14.90	7.7	299.61
1964	41.58	25.26	16.32	7.7	320.17
1965	44.48	27.44	17.04	7.8	346.94
1966	48.15	29.41	18.74	7.9	380.39
1967	54.08	32.44	21.64	8.3	448.86
1968	61.38	36.61	24.77	8.4	515.59
1969	70.03	41.36	28.67	8.3	581.25
1970	81.01	47.30	33.71	8.2	664.28
1971	92.31	53.80	38.51	8.0	738.48
1972	105.30	59.80	45.50	7.9	831.70
1973	102.40	57.00	45.40	7.8	798.70
1974	113.60	61.90	51.70	7.8	886.10
1975	133.80	70.90	62.90	7.7	1,030.30
1976	151.80	78.00	73.80	7.7	1,168.90
1977	174.00	87.40	86.60	7.6	1,322.40
1978	194.34	96.59	97.75	7.6	1,474.21
1979	217.34	107.37	109.97	7.6	1,641.48
1980	245.12	119.13	125.99	7.6	1,850.96
1981	284.33	138.18	146.15	7.6	2,171.20
1982	327.37	158.12	169.25	7.6	2,500.52
1983	369.49	176.25	193.24	7.6	2,789.18
1984	411.10	194.04	217.06	7.3	2,995.38
1985	460.19	213.07	247.12	7.1	3,244.74

*Adjusted expenses per admission is the average expense to the hospital in providing care for one inpatient stay. These expenses are derived by subtracting outpatient expenses from total expenses, and dividing the resulting amount by total admissions. Adjusted expenses per inpatient day covers expense of inpatient care only and is derived by dividing expenses by inpatient days.

NOTE: Data prior to 1972 include hospital units of institutions. Total expenses include: payroll expenses; employee benefits; professional fees; depreciation expense; supplies and purchased services. Payroll expenses include: physicians' and dentists' salaries; other personnel. Prior to 1972 payroll expenses also included: medical and dental interns and residents, trainees in medical technology and administration. Data for 1973-1985 have been adjusted to include data for outpatients on an inpatient equivalency basis.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions) and Health Insurance Association of America.

Table 5.16
Community Hospital Statistics, 1985

State	Average cost to hospital per day	Average length of hospital stay	Average cost to hospital per stay
Alabama	\$388.94	6.9	\$2,653.32
Alaska	693.44	5.4	3,741.70
Arizona	591.15	6.1	3,546.73
Arkansas	380.50	6.0	2,292.06
California	653.70	6.2	4,049.96
Colorado	486.25	6.6	3,221.15
Connecticut	502.43	7.2	3,609.67
Delaware	474.16	7.1	3,356.62
District of Columbia	612.28	8.1	4,961.60
Florida	494.09	6.9	3,381.46
Georgia	385.71	6.5	2,500.86
Hawaii	420.11	8.3	3,521.74
Idaho	372.60	6.4	2,402.41
Illinois	498.18	7.3	3,607.22
Indiana	445.97	6.6	2,941.64
Iowa	359.05	7.6	2,734.54
Kansas	400.99	7.4	2,953.58
Kentucky	366.77	6.4	2,322.68
Louisiana	475.05	6.0	2,841.93
Maine	393.79	7.3	2,870.23
Maryland	442.72	7.3	3,237.37
Massachusetts	499.61	8.4	4,193.71
Michigan	507.37	7.3	3,686.40
Minnesota	368.72	9.0	3,301.81
Mississippi	319.13	6.4	2,036.79
Missouri	456.92	7.4	3,383.20
Montana	312.24	8.6	2,658.42
Nebraska	347.06	8.4	2,832.07
Nevada	677.07	5.9	3,953.14
New Hampshire	421.98	6.3	2,644.11
New Jersey	400.27	7.3	2,914.07
New Mexico	501.37	5.7	2,837.43
New York	419.30	9.4	3,929.98
North Carolina	355.73	6.8	2,416.31
North Dakota	321.59	9.2	2,917.58
Ohio	493.25	7.0	3,427.50
Oklahoma	455.25	6.2	2,814.37
Oregon	549.03	5.3	2,878.89
Pennsylvania	468.07	7.3	3,412.17
Rhode Island	447.27	7.7	3,432.11
South Carolina	357.84	7.0	2,508.00
South Dakota	282.05	8.7	2,442.00
Tennessee	397.34	6.8	2,708.91
Texas	460.98	6.1	2,798.88
Utah	556.48	5.1	2,799.46
Vermont	342.98	7.9	2,705.09
Virginia	399.29	7.2	2,861.83
Washington	545.94	5.6	3,061.91
West Virginia	399.27	6.3	2,519.69
Wisconsin	391.61	7.6	2,973.61
Wyoming	366.79	6.5	2,356.83
Total U.S.	460.19	7.1	3,244.74

SOURCE: American Hospital Association, *Hospital Statistics*, 1986.

Table 5.17
Comparison of Hospital Semiprivate Room Charges by State

State	January 1986	January 1987	Percent change
Alabama	\$173.42	\$188.46	8.7%
Alaska	326.21	371.53	13.9
Arizona	242.63	259.24	6.8
Arkansas	148.97	153.69	3.2
California	300.45	327.01	8.8
Colorado	225.71	243.30	7.8
Connecticut	226.56	247.15	9.1
Delaware	273.40	278.85	2.0
District of Columbia	332.31	373.97	12.5
Florida	194.38	208.37	7.2
Georgia	149.64	159.81	6.8
Hawaii	252.89	266.51	5.4
Idaho	205.51	222.68	8.4
Illinois	261.18	279.44	7.0
Indiana	192.81	207.65	7.7
Iowa	185.79	194.32	4.6
Kansas	197.95	213.09	7.6
Kentucky	187.12	198.77	6.2
Louisiana	171.64	187.76	9.4
Maine	212.97	221.76	4.1
Maryland	200.13	219.10	9.5
Massachusetts	241.64	262.23	8.5
Michigan	275.19	295.81	7.5
Minnesota	212.24	228.01	7.4
Mississippi	115.96	125.25	8.0
Missouri	195.88	209.35	6.9
Montana	206.99	220.50	6.5
Nebraska	163.19	174.02	6.6
Nevada	219.33	226.66	3.3
New Hampshire	207.15	219.12	5.8
New Jersey	200.64	215.25	7.3
New Mexico	212.48	226.91	6.8
New York	239.88	262.04	9.2
North Carolina	145.53	151.19	3.9
North Dakota	174.11	186.44	7.1
Ohio	237.79	252.89	6.4
Oklahoma	168.69	176.97	4.9
Oregon	246.16	263.10	6.9
Pennsylvania	277.11	294.37	6.2
Rhode Island	229.31	247.67	8.0
South Carolina	145.92	155.74	6.7
South Dakota	171.18	174.12	1.7
Tennessee	155.98	170.08	9.0
Texas	171.90	184.12	7.1
Utah	214.25	244.19	14.0
Vermont	233.91	256.77	9.8
Virginia	171.59	180.45	5.2
Washington	248.42	266.23	7.2
West Virginia	175.17	184.36	5.2
Wisconsin	170.85	174.21	2.0
Wyoming	161.46	179.49	11.2
Total U.S.	226.87	243.90	7.5

SOURCE: Health Insurance Association of America, Survey of Hospital Semi-Private Room Charges as of January 1987.

Table 5.18
Fees for Surgical and OBG Procedures
And Psychotherapy in the United States, 1986

Specialty	Median fee	Specialty	Median fee
General Surgeons		Neurosurgeons	
Appendectomy	\$ 700	Wrist ganglionectomy	\$ 601
Cholecystectomy	1,044	Cranioplasty	2,000
Inguinal hernia (unilateral)	670	Craniotomy	3,000
OBG Specialists		Lumbar laminectomy	2,122
Complete OB care (usual and routine)	\$1,001	Plastic Surgeons	
Total hysterectomy	1 400	Complete rhinoplasty	\$2,000
D&C (diagnostic)	366	Facial rhytidectomy	3,000
D&C (therapeutic)	365	Breast augmentation (bilateral)	2,000
Psychotherapy		Dermabrasion of facial scar	400
Individual in office (1 hr)	\$ 86	Excision of lipoma	300
Individual in hospital (1 hr)	91	Thoracic Surgeons	
Psychiatric consultation in office	96	Open heart surgery (with bypass)	\$4,001
Psychiatric consultation in hospital	101	Lobectomy	2,000
Group therapy/per person	36	Insertion of pacemaker	1,201
Family therapy (1½ hrs)	121	Thoracentesis	125
		Dilation of esophagus	201

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Table 5.19
Dental Fees Charged by General Practitioners
and Selected Specialists in the United States, 1985

Specialty	Fees		
	Mean	Mode	Median
General Practitioners			
Initial oral examination	\$ 15	\$ 10	\$ 14
Full mouth x-ray (4 bitewings)	17	20	16
Amalgam, two surfaces permanent	36	35	35
Crown, porcelain on gold	355	350	350
Crown, full high noble metal	338	350	335
Periodontics			
Gingivectomy per quadrant	263	250	250
Endodontics			
Therapeutic pulpotomy	62	50	55
Root canal	241	225	235
Orthodontists			
Comprehensive treatment (transitional dentition)			
Class 1 malocclusion	1,771	2,200	1,900
Comprehensive treatment (permanent dentition)			
Class 1 malocclusion	2,284	2,200	2,250

SOURCE: American Dental Association, Bureau of Economic and Behavioral Research. *Journal of the American Dental Association*, November 1986. Reprinted by permission.

Table 5.20
Median Office Visit Fees by Type of Physician and Type of Community, 1986

Type of Physician	First Office Visits			Office Revisits		
	Urban	Suburban	Rural	Urban	Suburban	Rural
D.O.s (GPs only)	\$26	\$26	\$22	\$21	\$22	\$19
FPs	31	30	24	25	25	20
GPs	30	29	23	22	22	20
All surgical specialists	46	46	36	26	26	23
All non-surgical specialists (Excluding FPs and GPs)	46	41	31	28	29	25

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Table 5.21
Regional Variations in Median Physician Fees, 1986

	First office visits				Office revisits			
	West	Midwest	South	East	West	Midwest	South	East
D.O.s (GPs only)	\$ 30	\$24	\$26	\$26	\$24	\$20	\$21	\$22
FPs	35	25	26	27	27	21	21	24
GPs	35	23	26	26	26	20	20	21
Internists	46	35	41	45	31	25	26	31
OBG specialists	60	41	50	51	34	26	28	36
Pediatricians	39	30	31	35	29	23	25	26
General surgeons	41	26	30	40	25	21	21	26
Neurosurgeons	125	76	86	96	35	26	30	35
Orthopedic surgeons	51	36	40	51	31	22	25	30
Plastic surgeons	40	35	36	51	25	21	25	30
Thoracic surgeons	66	51	51	66	30	21	25	26
All surgical specialists	50	36	41	51	30	24	25	31
All non-surgical specialists (Except FPs and GPs)	51	35	37	46	30	25	26	31

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Table 5.22**Total Medical Costs of Hospital-Based Obstetrical Delivery, 1986**

	Usual delivery		
	Labor and delivery room	Birth room	Cesarean
Northeast			
Metropolitan	\$3,000	\$2,750	\$4,280
Nonmetropolitan	2,610	2,400	4,150
Total	2,880	2,640	4,200
South			
Metropolitan	2,510	2,440	4,020
Nonmetropolitan	2,320	2,240	3,870
Total	2,390	2,330	3,950
Midwest			
Metropolitan	2,730	2,540	4,540
Nonmetropolitan	2,250	2,120	3,980
Total	2,460	2,300	4,220
West			
Metropolitan	3,090	3,000	5,440
Nonmetropolitan	2,260	2,160	4,380
Total	2,730	2,650	4,930
U.S.			
Metropolitan	2,800	2,680	4,450
Nonmetropolitan	2,340	2,220	4,040
Total	2,560	2,450	4,270

SOURCE: Health Insurance Association of America, Public Relations Division, *The Cost of Having a Baby*.

Table 5.23**Certain Costs of Accidents by Class, 1985 (000,000,000 omitted)**

Cost	Total*	Motor vehicle	Work	Home	Public nonmotor vehicle
Total	\$107.3	\$48.6	\$37.3	\$14.0	\$9.4
Wage loss	31.2	16.1	7.4	4.3	4.8
Medical expense	17.8	3.9	5.4	5.7	3.4
Insurance administration	14.2	9.3	4.7	0.1	0.1
Fire loss	7.3	†	2.3	3.9	1.1
Motor vehicle property damage	19.3	19.3	†	†	†
Indirect work loss	17.5	†	17.5	†	†

*Duplications between work and motor vehicle and home and motor vehicle are eliminated in the totals.

†Not included.

SOURCE: *Accident Facts*, 1986 edition, Copyright © 1986 by National Safety Council. Reprinted by permission.

Chapter 6

Disability and Health Care Utilization

Disability

Disability rates for both acute and chronic health conditions—as measured by work-loss days, restricted activity days and disability days—vary by social and economic characteristics. Table 6.1 shows that the higher the income, the fewer days of disability from acute health conditions. Marked differences in the number of disability days are also found in relation to the sex of the worker. Females averaged 8.1 days of restricted activity per person, while males had 5.6 per person in 1985.

Among the geographical regions of the United States, the South had more restricted activity days (16.3) per person due to chronic and acute conditions, while the Northeastern region showed the highest number of work-loss days per person.

Acute Conditions. Some 333 million workdays were lost in 1985 as a result of all acute health conditions. (For definition, see footnote, Table 6.3.) This was an average of 3.1 days off the job for each worker in the nation.

A rate of 3.9 school-loss days per child between the ages of 5 and 17 was reported for 1985.

Chronic Conditions. Chronic illness invariably has a long-term impact on people, changing their lifestyles to the extent that they can no longer carry on their major activity, such as working or

keeping house, or limiting the kind or duration of their activities. In 1985, 33 million persons, 14.0% of the U.S. civilian noninstitutional population, suffered a limitation of activity because of one or more chronic conditions (Table 6.5). Some 22 million, or 9.5% of Americans, suffered limitation of their major activity.

Occupational Injuries and Illness.

According to the U.S. Department of Labor's latest survey, approximately 5.4 million work-related injuries occurred in 1985. (Table 6.6).

Some 44.1 million workdays were lost because of work-related injuries in 1985—up from 41.9 million in 1984. The average per incident increased from 17 lost workdays in 1984 to 18 in 1985.

About 126,000 reported cases of occupational illnesses were recorded in 1985, compared with 125,000 in 1984.

Social Security Disability Insurance Program. The Social Security Disability Insurance program is the largest federal income program for disabled persons. Table 6.7 shows the growth of the Disability Insurance program from 1965 to 1986. The number of recipients (both the number of workers, and the number of workers and dependents) was greatest in 1978, and had decreased each year since, until 1984, when it rose again.

Trends in Utilization Of Services

Hospital Utilization. Approximately one of seven Americans (based on the civilian noninstitutional population) was admitted to a community hospital in 1985. Community hospitals, defined as nonfederal, short-term, general and special hospitals providing general medical care to the public, account for 83% of all hospitals and handle 92% of all admissions.

An average of 91,641 persons entered community hospitals each day in 1985—33,449,000 admissions over the 12-month period. This was a 4.9% decrease from 1984.

On an average day in 1985, there were 648,892 patients in community hospitals, or 2.8 per 1,000 population.

The nation's community hospitals treated 219 million outpatient cases in 1985. This was a 14.7% increase over 1975.

A National Center for Health Statistics survey of short-stay hospital utilization in 1985 reported the average length of stay was 6.9 days for males and 6.2 days for females. Females, however, had a higher rate of hospitalization than males, 171 per 1,000 compared to 124 per 1,000 for men. Length of stay increased with age from 4.6 days for children under 15, to 8.7 days for persons aged 65 and over. The Northeast registered the longest average length of stay, 7.7 days for all ages, while the Western region had the shortest, 5.4 days.

Physician Visits. According to estimates of the U.S. Department of Health and Human Services' *National Health*

Interview Survey, Americans made 1,239 million visits to physicians in 1985. The average number of visits per person was 5.3. (For definition, see Table 6.13.)

A government survey of ambulatory patient visits in 1986 (where there was contact with a physician) showed that the largest proportion of office visits, 30.5%, were made to general and family practitioners. Some 11.4% of office visits were for medical examinations, 2.6% for post-surgery checkups and the remaining 86% were for acute or chronic conditions. Some 51% of these office visits were made to solo practitioners and 49% were made to physicians engaged in multiple-member practices.

Office visits per year increased in direct proportion to advancing age. About 61% of all office visits by adults were made by women.

Diseases of the respiratory system accounted for 12.1% of all visits and another 8.8% of visits were for diseases of the circulatory system.

The following eight diagnostic groups accounted for 74% of the principal diagnoses made by physicians in office practice.

	Percent
Special conditions and examinations without illness	15.3
Diseases of the respiratory system	12.1
Diseases of the nervous system and sense organs	11.0
Diseases of the circulatory system	8.8
Injuries and poisonings	8.3
Diseases of the musculoskeletal system and connective tissue	7.1
Diseases of the genitourinary system	6.1
Diseases of the skin and subcutaneous tissue	5.7

Table 6.1
Disability Due to Acute Conditions, by Social
and Economic Characteristics in the United States, 1985
 (Days per person)

Characteristics	Restricted activity	Bed disability	Work-loss
Sex			
Both Sexes	6.9	3.0	3.1
Male	5.6	2.4	2.6
Female	8.1	3.7	3.7
Family Income			
Under \$10,000	8.8	4.1	4.0
\$10,000-19,999	7.8	3.4	N.A.
\$20,000-34,999	6.5	2.7	N.A.
\$35,000 and over	5.5	2.4	N.A.
Place of Residence			
Metropolitan Statistical Area	7.0	3.1	3.2
Other Statistical Area	6.5	2.9	2.9
Age			
Under 5 years	7.5	3.5	—
5-17 years	6.5	3.3	—
18-24 years	6.8	2.6	3.4
25-44 years	6.5	2.8	3.3
45-64 years	6.0	2.7	2.6
65 years and older	9.6	3.9	—

N.A. = Not available.

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. "Family income" includes the total income of each member of the family.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey: United States 1985*.

Table 6.2
Selected Health Characteristics by Geographic Region
in the United States, 1985 (Days/visits per person)

Characteristics	Total	Geographic region			
		Northeast	Midwest	South	West
Restricted activity days*	14.8	13.8	12.7	16.3	15.7
Days of bed disability*	6.1	5.5	5.6	6.9	6.3
Work-loss days*	5.3	5.7	5.1	5.0	5.3
Physician visits	5.3	5.2	5.4	5.0	5.6

*Chronic and acute conditions.

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. A "Physician visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice. A "Dental visit" is any visit to a dentist's office for treatment or advice.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey: United States 1985* and unpublished data.

Table 6.3
Workdays Lost Due to Acute Conditions in the
United States, 1985

Acute Conditions	Number of work-loss days (000,000)			Work-loss days per employed person		
	All ages 18 and over	Age 18-44	Age 45 and over	All ages 18 and over	Age 18-44	Age 45 and over
Both Sexes						
All acute conditions	333	249	84	3.1	3.3	2.6
Infective and parasitic diseases	27	23	4	0.2	0.3	0.1
Respiratory conditions	116	84	32	1.1	1.1	1.0
Digestive system conditions	20	10	10	0.2	0.1	0.3
Injuries	112	89	23	1.0	1.1	0.7
All other acute conditions	58	43	15	0.5	0.6	0.5
Male						
All acute conditions	157	114	43	2.6	2.7	2.4
Infective and parasitic diseases	10	9	1	0.2	0.2	0.1
Respiratory conditions	51	38	13	0.8	0.9	0.7
Digestive system conditions	10	4	6	0.2	0.1	0.3
Injuries	73	57	16	1.2	1.4	0.9
All other acute conditions	13	6	7	0.2	0.1	0.4
Female						
All acute conditions	177	136	41	3.7	4.0	2.9
Infective and parasitic diseases	16	14	2	0.3	0.4	0.2
Respiratory conditions	66	47	19	1.4	1.4	1.4
Digestive system conditions	10	6	4	0.2	0.2	0.3
Injuries	40	32	8	0.8	0.9	0.6
All other acute conditions	45	38	8	0.9	1.1	0.6

NOTE: The data refer to the civilian, noninstitutional population. An acute condition is one which lasted less than 3 months and which involved either medical attention or restricted activity. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. In some cases the sum of the items does not equal the total shown, because of rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey: United States 1985*.

Table 6.4

**Days Lost from School Per 100 Children (5-17 years)
Per Year, Due to Acute Conditions, by Sex and Condition
Group, United States, 1985**

Condition Group	Both sexes	Male	Female
All acute conditions	386.9	347.9	427.6
Infective and parasitic diseases	93.9	87.1	101.1
Respiratory conditions	215.6	189.9	242.4
Upper respiratory conditions	91.2	86.2	96.4
Influenza	104.7	88.2	122.0
Other respiratory conditions	19.6	15.5	24.1
Digestive system conditions	12.9	14.6	11.1
Injuries	23.6	27.6	19.5
All other acute conditions	40.8	28.7	53.5

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey, United States 1985*.

Table 6.5

**Percent Distribution of Persons with Limitation of Activity
Due to Chronic Conditions, by Degree of Limitation
According to Sex and Age, United States, 1985**

Sex and age	Total with activity limitation	With limitation in major activity	Limited but not in major activity
All persons			
All ages	14.0%	9.5%	4.5%
Under 18 years	5.1	3.7	1.5
18-44 years	8.4	5.7	2.8
45-64 years	23.4	17.5	5.9
65-69 years	39.2	31.1	8.1
70 years and over	39.8	20.4	19.4
Male			
All ages	13.6	9.7	3.9
Under 18 years	6.0	4.4	1.6
18-44 years	8.8	6.2	2.6
45-64 years	22.5	18.3	4.2
65-69 years	40.9	36.3	4.6
70 years and over	38.1	16.5	21.6
Female			
All ages	14.4	9.4	5.0
Under 18 years	4.2	2.9	1.3
18-44 years	8.1	5.2	2.9
45-64 years	24.2	16.7	7.4
65-69 years	37.8	27.0	10.8
70 years and over	40.9	23.0	18.0

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey, United States 1985*.

Table 6.6
Number of Occupational Injuries and Illnesses, and Lost
Workdays, Private Sector, by Industry Division,
United States, 1985

Industry	Total cases* (000)	Lost workday cases (000)	Total lost workdays (000)	Average lost workdays per lost workday case
Injuries and illnesses				
Private sector†	5,507	2,537	45,189	18
Agriculture, forestry and fishing†	92	46	736	16
Mining	78	44	1,342	31
Construction	613	275	5,196	19
Manufacturing	1,938	857	14,974	17
Transportation and public utilities	423	246	5,269	21
Wholesale and retail trade	1,357	593	9,261	16
Wholesale trade	387	190	3,225	17
Retail trade	970	403	6,037	15
Finance, insurance and real estate	104	47	818	17
Services	904	428	7,592	18
Injuries				
Private sector†	5,382	2,485	44,050	18
Agriculture, forestry and fishing†	88	45	726	16
Mining	77	44	1,333	30
Construction	607	273	5,165	19
Manufacturing	1,865	825	14,213	17
Transportation and public utilities	417	244	5,231	21
Wholesale and retail trade	1,345	588	9,131	16
Wholesale trade	383	188	3,189	17
Retail trade	963	400	5,941	15
Finance, insurance and real estate	101	46	777	17
Services	882	421	7,475	18
Illnesses				
Private sector†	126	52	1,139	22
Agriculture, forestry and fishing†	3	1	10	10
Mining	1	1	9	9
Construction	6	2	31	16
Manufacturing	72	32	761	24
Transportation and public utilities	6	3	37	12
Wholesale and retail trade	11	5	131	26
Wholesale trade	4	1	36	36
Retail trade	8	3	95	32
Finance, insurance and real estate	3	2	41	21
Services	22	8	118	15

*Includes fatalities.

†Excludes farms with fewer than 11 employees.

NOTE: Because of rounding, the sum of the components may not add to the totals. Differences between the estimate of total cases and the estimates for lost workday cases and nonfatal cases without lost workdays may not reflect the fatality estimate.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 6.7
Growth in the Social Security Disability Insurance Program

Year	Number of workers insured for disability (000,000 omitted)	Disabled workers receiving benefits		Total disability insurance beneficiaries (000 omitted)	Total cash benefits paid for disability (000,000,000 omitted)
		Number (000 omitted)	Number per 100,000 insured workers		
1965	53.3	988.1	1,854	1,739.1	\$ 1.6
1966	55.0	1,097.2	1,995	1,970.3	1.8
1967	55.7	1,193.1	2,142	2,140.2	1.9
1968	56.9	1,295.3	2,276	2,335.1	2.3
1969	70.1	1,394.3	1,989	2,487.5	2.5
1970	72.4	1,492.9	2,062	2,665.0	3.1
1971	74.5	1,647.7	2,212	2,930.0	3.8
1972	76.1	1,832.9	2,409	3,271.5	4.5
1973	77.8	2,016.9	2,592	3,559.0	5.7
1974	80.4	2,236.9	2,782	3,911.3	6.9
1975	83.3	2,488.8	2,988	4,352.2	8.4
1976	85.3	2,670.2	3,130	4,623.8	10.0
1977	87.0	2,837.4	3,261	4,860.4	11.5
1978	89.3	2,879.8	3,225	4,868.5	12.5
1979	93.7	2,870.6	3,064	4,777.4	13.7
1980	98.0	2,858.7	2,917	4,682.2	15.4
1981	100.5	2,776.5	2,763	4,456.3	17.2
1982	102.4	2,603.6	2,543	3,973.5	17.3
1983	103.6	2,569.0	2,480	3,812.9	17.5
1984	106.6	2,596.5	2,436	3,821.8	17.9
1985	109.2	2,656.5	2,433	3,907.2	18.8
1986	111.3	2,727.4	2,450	3,993.3	19.9

N.A.—Not Available.

NOTE: Number of disabled workers in current payment status as of December 31 of the year indicated. Insured workers as of January 1 of the year indicated.

SOURCES: U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin*, Annual Supplements; U.S. Senate, Committee on Finance, *Staff Data and Materials Related to the Social Security Disability Insurance Program*, 1983; and unpublished data.

Table 6.8
Utilization of Community Hospitals in the United States
 (Per 1,000 Population)

Year	Beds	Average daily census	Admissions
1950	3.4	2.5	111.4
1955	3.5	2.5	117.3
1960	3.6	2.7	129.2
1965	3.9	3.0	138.8
1970	4.2	3.3	145.6
1971	4.3	3.3	148.2
1972	4.3	3.2	150.0
1973	4.3	3.3	153.2
1974	4.4	3.3	157.0
1975	4.5	3.3	158.1
1976	4.5	3.3	159.1
1977	4.5	3.3	158.9
1978	4.6	3.3	158.3
1979	4.5	3.3	159.2
1980	4.4	3.3	162.1
1981	4.5	3.4	161.9
1982	4.5	3.4	160.2
1983	4.4	3.3	157.6
1984	4.4	3.0	151.8
1985	4.3	2.8	143.1

NOTE: Some data are revised. Data refer to the civilian noninstitutional population.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions).

Table 6.9
Rate of Discharges and Average Length of Stay for Patients
Discharged from Short-Stay Non-Federal Hospitals, by Sex,
United States, 1985 (Excludes Newborn Infants)

First listed diagnostic category	Rate of discharges per 1,000 population			Average length of stay (days)		
	Total	Male	Female	Total	Male	Female
All conditions	147.9	123.6	170.7	6.5	6.9	6.2
All ischemic heart disease	8.7	10.5	6.9	7.1	6.8	7.5
Malignant neoplasms and carcinoma-in-situ	8.1	7.8	8.3	8.9	9.1	8.7
Benign neoplasms and neoplasms of uncertain behavior	2.1	1.0	3.1	5.5	4.7	5.7
Fractures, all sites	4.8	4.8	4.7	8.7	7.7	9.8
Diseases of the urinary system	4.8	4.9	4.6	5.9	5.6	6.1
Pneumonia, all forms	3.6	3.8	3.4	7.9	7.8	8.1
Chronic disease of tonsils and adenoids	1.2	1.1	1.3	1.5	1.5	1.6
Cerebrovascular disease	3.9	3.6	4.1	10.5	10.0	10.9
Diabetes mellitus	2.0	1.7	2.3	8.1	8.0	8.2
Inguinal hernia	1.6	3.0	0.3	3.2	3.1	4.0
Cholelithiasis	2.0	1.2	2.7	7.5	8.3	7.2
Appendicitis	1.1	1.3	0.9	5.0	5.1	4.9
Childbirth	—	—	68.1*	—	—	3.3
With complications	—	—	43.6*	—	—	3.7
Without complications	—	—	24.5*	—	—	2.5

*Rate of discharge for childbirth is based on population of women aged 15-44.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Table 6.10
Rate of All Listed Surgical Operations for Patients
Discharged from Short-Stay Non-Federal Hospitals,
by Age and Sex, United States, 1985

Age	Rate per 1,000 population		
	Both sexes	Male	Female
Total	104.6	76.8	130.6
Under 15 years	26.6	31.3	21.8
15-44 years	108.0	49.4	165.0
45-64 years	120.0	116.4	123.3
65 years and over	209.2	239.5	188.7

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Table 6.11
Rate of All Surgical Procedures for Inpatients Discharged
from Short-Stay Non-Federal Hospitals, by Sex, United
States, 1985

Procedure	Per 100,000 population		
	Both sexes	Male	Female
All operations	15,508	12,820	18,025
Operations on the nervous system	379	394	365
Operations on the endocrine system	40	21	58
Operations on the eye	303	269	335
Operations on the ear	108	114	103
Operations on the nose, mouth and pharynx	495	514	477
Operations on the respiratory system	414	508	325
Operations on the cardiovascular system	1,018	1,243	808
Operations on the hemic and lymphatic system	168	166	169
Operations on the digestive system	2,422	2,207	2,623
Operations on the urinary system	729	915	555
Operations on the male genital organs	314	649	—
Operations on the female genital organs	1,400	—	2,710
Obstetrical procedures	1,816	—	3,516
Operations on the musculoskeletal system	1,486	1,513	1,462
Operations on the integumentary system	697	575	812
Miscellaneous diagnostic and therapeutic procedures	3,721	3,734	3,708

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, "1985 Summary: National Hospital Discharge Survey," *Advanced data* No. 127, September 25, 1986.

Table 6.12
Selected Community Hospital Facilities, Services and
Special Beds in the United States, 1985

Selected facility or service	Percent of community hospitals
Emergency department	95.2%
Rehabilitation outpatient	39.3
Family planning services	11.5
Open-heart surgery facilities	12.2
X-ray therapy	18.2
Megavoltage therapy	17.2
Radioactive implants	24.9
Organ transplant	4.9
Blood bank	73.6
Respiratory therapy	93.7
Premature nursery	30.6
Speech pathology services	47.5
Hemodialysis (inpatient)	27.7
Genetic counseling services	8.4
Physical therapy	91.1
Occupational therapy	43.1
Psychiatric partial hospitalization program	10.7
Psychiatric outpatient services	15.3
Alcoholism/chemical dependency outpatient services	16.1
Home care department	29.7
Hospice	12.9
CT scanners	55.5
Health promotion	51.9

SOURCE: American Hospital Association, *Hospital Statistics*, 1986.

Table 6.13
Number of Physician Visits Per Person in the
United States, 1985

	All ages	Under 18 years	18-44 years	45-64 years	65 years and over
Both sexes	5.3	4.3	4.7	6.1	8.3
Male	4.4	4.3	3.3	5.4	7.8
Female	6.1	4.2	6.1	6.8	8.7

NOTE: The data refer to the civilian, noninstitutional population. A "Physician Visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey, United States 1985*.



Chapter 7

Health Manpower

According to the Department of Labor, some 6.3 million persons were active in the health field in 1985.

Physicians

According to the U.S. Department of Health and Human Services, the number of active physicians is projected to grow from approximately 506,500 in 1984 to 588,000 in 1990, an annual average increase of 2.5% or almost three times the growth in population for the same period.

An increasing number of physicians become affiliated with health maintenance organizations every year. *Medical Economics* magazine reports that nearly half of the practicing physicians have now joined HMOs (Table 7.2).

There is also mounting evidence of widespread acceptance by physicians of the preferred provider organization (PPO) concept. By year-end 1986, physicians had signed over 521,000 contracts with PPOs, according to a directory of PPOs published by the American Medical Care and Review Association. The Association also reported 453 operational PPOs in the United States and 52 that were pre-operational as of December 1986 (Table 7.3).

The most recent estimates (Table 7.4) show that the District of Columbia has the highest ratio of nonfederal physicians to population, followed by Maryland, Massachusetts, New York and Connecticut. The lowest ratios of

physicians to populations occur in Mississippi, Idaho, Wyoming and Alaska.

Dentists

In 1984, the number of active dentists in the United States reached an estimated 132,750. According to the latest available state data (Table 7.4), the District of Columbia, Connecticut, Massachusetts, New York and Oregon had the highest ratios of dentists to population, while Mississippi, Arkansas, Alabama and South Carolina had the lowest. According to a survey conducted by the American Dental Association, approximately 1% of the dentists in private practice in the United States now practice in HMOs.

Nurses

Between 1965 and 1984, the number of registered nurses employed in nursing more than doubled to reach 1,485,725. The data, while excluding inactive nurses, include those employed in nursing on a part-time basis.

Pharmacists

There were an estimated 156,960 nonfederal licensed pharmacists in the United States in 1984.

About 72% of active pharmacists practice privately in community pharmacies, and 20% practice full- or part-time in hospitals. Other pharmacists are employed by manufacturers, taught or are engaged in other pharmaceutical activities such as research.

Table 7.1
Estimated Active Health Professionals in the United States
 (50 States and District of Columbia)

Year	Total Number			Per 100,000 Population*		
	Physicians	Dentists	Nurses	Physicians	Dentists	Nurses
1965	288,700	96,000	613,000	146	49	317
1970	326,500	102,200	722,000	156	50	356
1971	322,228	N.A.	750,000	156	N.A.	366
1972	333,259	105,500	780,000	160	51	376
1973	338,111	N.A.	815,000	161	N.A.	390
1974	369,900	110,400	857,000	173	52	402
1975	384,400	112,450	906,000	178	52	420
1976	399,500	115,000	961,000	179	53	449
1977	405,900	117,900	1,055,400	180	53	408
1978	424,000	129,600	1,123,200	187	54	506
1979	440,400	123,500	1,199,700	192	55	534
1980	457,500	126,240	1,272,900	201	56	560
1981	466,700	129,180	1,315,500	203	56	574
1982	479,900	132,010	1,357,300	207	57	586
1983	492,900	135,120	1,404,000	210	58	600
1984	506,500	137,950	1,485,725	214	58	628

N.A.—Not available.

*Resident population of 50 states and District of Columbia.

NOTE: Data are revised from previous editions and include federally-employed professionals in the 50 states and the District of Columbia. "Physicians" refers to all active physicians. "Dentists" refers to all active dentists. "Nurses" refers to registered nurses employed in nursing.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration. *Health Care Financing Review*, Spring 1986.

Table 7.2
Percentage of Practicing Physicians Affiliated with Health Maintenance Organizations, United States, 1986

Number of HMOs affiliated with	West	Midwest	South	East
6 or more	9%	2%	2%	*
5	5	2	1	*
4	5	5	3	2%
3	12	13	6	6
2	13	18	11	11
1	11	22	14	21
None	45	38	63	60

*Less than .05%.

SOURCE: *Medical Economics* magazine, March 2, 1987. Copyright © and published by Medical Economics Company, Inc., at Oradell, N.J. 07649. Reprinted by permission.

Table 7.3
Number of Preferred Provider Organizations, By Geographical Region of the United States, 1986

	Total	Number of PPOs*	
		Operational	Pre-Operational
Northeast	47	35	12
South	146	128	18
West	173	166	7
Midwest	139	124	15
Total	505	453	52

*States without PPOs are Alaska, Delaware, Idaho, Maine, Montana, New Hampshire, North Dakota, Rhode Island and South Dakota.

SOURCE: American Medical Care and Review Association, *Directory of Preferred Provider Organizations and Industry Report on PPO Development*, December 1986.

Table 7.4
Number and Rate Per 100,000 Population of Active
Physicians, Dentists, Pharmacists and Nurses, by State, 1984

State	Physicians		Pharmacists		Dentists		Nurses	
	Number	Rate*	Number	Rate**	Number	Rate*	Number	Rate**
Alabama	5,653	142	3,477	87	1,560	39	19,750	495
Alaska	634	127	178	35	276	56	3,256	651
Arizona	5,804	184	2,138	70	1,381	45	19,015	623
Arkansas	3,202	136	2,103	89	893	38	10,258	437
California	61,267	235	10,974	43	15,829	62	141,834	554
Colorado	6,243	196	1,976	62	2,025	64	21,212	667
Connecticut	8,685	275	2,291	72	2,400	76	26,407	837
Delaware	1,141	185	274	45	284	47	4,423	722
District of Columbia	3,415	552	784	127	568	92	9,465	1,519
Florida	21,474	191	4,935	45	4,927	45	67,722	617
Georgia	9,399	159	3,742	64	2,492	43	29,365	503
Hawaii	2,116	212	325	31	636	64	6,462	622
Idaho	1,174	118	632	63	538	54	5,039	503
Illinois	22,921	199	7,303	63	6,683	58	80,564	700
Indiana	7,823	142	4,690	85	2,557	46	32,240	586
Iowa	3,929	136	2,623	90	1,643	56	23,704	815
Kansas	3,916	162	1,715	70	1,219	50	15,943	664
Kentucky	5,500	149	2,731	73	1,863	50	16,799	451
Louisiana	7,698	173	2,515	56	1,846	42	17,372	389
Maine	1,904	165	763	66	565	49	8,453	731
Maryland	13,163	303	2,811	64	2,836	66	31,565	726
Massachusetts	17,396	300	5,483	94	4,319	74	63,540	1,096
Michigan	15,805	174	7,965	87	5,583	61	56,449	622
Minnesota	8,506	203	3,576	86	2,858	68	32,229	774
Mississippi	3,022	117	2,218	85	866	33	10,577	407
Missouri	8,982	179	4,366	87	2,677	53	31,866	636
Montana	1,121	136	698	84	517	63	5,260	638
Nebraska	2,481	156	1,586	98	1,075	67	11,094	691
Nevada	1,431	155	444	49	408	45	4,849	532
New Hampshire	1,774	179	575	59	541	55	8,024	821
New Jersey	16,486	219	4,419	59	5,061	67	52,493	699
New Mexico	2,302	161	925	65	665	47	7,255	509
New York	50,943	287	9,256	52	12,963	73	133,310	752
North Carolina	10,320	168	4,369	71	2,549	42	32,460	527
North Dakota	1,055	157	693	101	351	52	5,637	822
Ohio	19,555	182	6,314	58	5,843	54	75,676	704
Oklahoma	4,502	138	2,371	72	1,403	43	13,569	411
Oregon	5,073	189	1,839	68	1,959	73	18,081	676
Pennsylvania	25,324	214	8,315	70	6,984	59	91,238	767
Rhode Island	2,144	223	862	89	512	53	8,851	920
South Carolina	4,812	146	2,869	87	1,335	41	13,761	417
South Dakota	910	130	673	95	365	52	5,164	731
Tennessee	8,318	176	3,962	84	2,516	53	25,302	536
Texas	25,952	160	10,128	63	6,768	43	72,320	452
Utah	2,805	171	1,055	64	1,054	64	7,151	433
Vermont	1,239	232	293	55	330	62	4,639	875
Virginia	10,752	194	3,746	66	2,905	53	28,477	505
Washington	8,526	196	3,139	72	2,993	69	30,100	692
West Virginia	3,018	156	1,366	70	859	44	10,485	537
Wisconsin	8,186	172	4,058	85	3,207	67	32,351	679
Wyoming	633	125	417	81	263	52	2,667	522
Total U.S.	470,434	199	156,960	66	132,750	56	1,485,723	629

*Based on civilian population.

**Based on resident population.

Note: Estimates of "Physicians" exclude federally-employed physicians and doctors of osteopathy. "Dentists" exclude military and federally-employed dentists.

Source: Health Resources and Services Administration, Bureau of Health Professions, Office of Data Analysis and Management, U.S. Department of Health and Human Services.

Historic Dates

- | | | | |
|-------|---|-------|--|
| 1798 | U.S. Marine Hospital Service established by U.S. Congress. Compulsory deductions for hospital service were made from seamen's wages. | | of accident protection. It was the first company to issue insurance on a basis resembling its present form. |
| 1847 | The first insurer to issue sickness insurance was organized: The Massachusetts Health Insurance Company of Boston. | 1875 | A number of mutual benefit associations, called "establishment funds," were formed for employees of a single employer. The benefits provided usually included small payments for death and disability. |
| 1849 | New York State passed the first general insurance law. | | |
| 1850s | The first insurance supervisory boards were created in New Hampshire, Massachusetts, Rhode Island and Vermont. | 1890 | Policies providing benefits for disability from specified diseases were first offered. |
| 1850 | Individual accident insurance became available in the United States with the chartering of the Franklin Health Assurance Company in Massachusetts. | 1890s | This period brought the promotion of many fraternal associations, assessment mutuals and industrial insurers. Because many of these companies and associations were inadequately financed and poorly managed, many states passed legislation against them. |
| 1851 | One of the earliest voluntary mutual protection associations, <i>La Societe Francaise de Bien-faisance Mutuelle</i> , was organized in San Francisco. It is noteworthy for having established a hospital in 1852 to provide care for its members. | 1900 | Shortly after the turn of the century, disability benefits became available for substantially all diseases. |
| 1855 | The first separate insurance department, independent of any established agency, was created in Massachusetts. | 1910 | Montgomery Ward & Co., Inc. replaced its "employee establishment fund" with an insured contract. This plan is generally regarded as the first group health insurance policy. |
| 1859 | The first full-time insurance commissioner was appointed in New York. | 1912 | The Standard Provisions Law drafted by the National Convention of Insurance Commissioners (now the NAIC) was enacted by most states. This model law sought to provide uniformity |
| 1863 | The Travelers Insurance Company of Hartford, Connecticut, offered accident insurance for railway mishaps; then all forms | | |

- ty and fairness in the "operating conditions" of the health insurance contract.
- 1916 First non-cancellable disability income contract was offered.
- 1917 Group accidental death and dismemberment insurance was first written.
- 1920s Early in this decade individual hospitals began offering hospital expense benefits on an individual prepaid basis.
- 1920s First partial disability benefits for sickness and accident became available.
- 1929 The first health maintenance organization, the Ross-Loos Clinic, was established in Los Angeles, California.
- 1929 A group of school teachers arranged for Baylor Hospital in Dallas, Texas to provide room and board and specified ancillary services at a predetermined monthly cost. This plan is considered the forerunner of what later became known as the Blue Cross plans.
- 1929 With the depression, many companies entered a period of retrenchment in their disability income product line, particularly in the area of maintaining reasonable indemnity limits in order to avoid overinsurance.
- 1930s The depression stimulated the expansion of insurance coverages through both public demand and hospitals' encouragement.
- 1932 First citywide Blue Cross plan was tried out with a group of hospitals in Sacramento, California.
- 1935 The Social Security Act (P.L. 74-241) provided for the first time grant-in-aid to states for such public health activities as maternal and child care, aid to crippled children, blind persons, the aged and other health-impaired persons.
- 1937 Health Service Plan Commission (Blue Cross Commission) was organized.
- 1938 Hospital insurance for dependents of covered persons was developed.
- 1938 Private insurers introduced group surgical expense benefit plans.
- 1939 The first Blue Shield plan (surgical-medical), called the California Physicians' Service, was developed.
- 1940s During World War II, as a result of the freezing of wages, group health insurance became an important component of collective bargaining for employee benefits.
- 1942 Compulsory cash sickness benefits were begun by four states (Rhode Island, 1942; California, 1946; New Jersey, 1948; New York, 1949).
- 1943 Private insurers introduced group medical expense benefits (physician's visits expense benefits).
- 1946 The Health Insurance Council, a federation of eight insurance associations organized to give technical and practical assistance on health insurance to the providers of medical care, was formed.
- 1946 Blue Shield Medical Care Plans, Inc. (Blue Shield Commission) was organized.

- 1948 The National Labor Relations Board ruled, in a dispute between the United Steel-workers' Union and the Inland Steel Company, that the term "wages" be construed to include pension and insurance benefits. The U.S. Supreme Court upheld this ruling in a 1949 decision.
- 1949 Major medical expense benefits were introduced by Liberty Mutual Insurance Company to supplement basic medical care expenses.
- 1954 Congress introduced the disability "freeze" that stated that the quarters during which a worker is disabled are not counted in determining the number of quarters needed to be fully or currently insured under Old Age and Survivors Insurance (OASI).
- 1956 Disability insurance was added to the Social Security System, providing monthly cash benefits for insured persons who are totally disabled.
- 1957 Vision care expense benefits were introduced by private insurers, followed in 1959 by extended care facility expense benefits.
- 1959 Continental Casualty Company issued the first comprehensive group dental insurance plan written by an insurance company.
- 1960s First disability contracts for business use appeared (overhead expense, keyman).
- 1960s Eligibility for disability benefits under Social Security was expanded.
- 1961 First state enrollment plan was made available by Connecticut to persons 65 and over on a state basis and under special enabling legislation allowing the pooling of risks by a group of insurance companies (Associated Connecticut Health Insurance Companies).
- 1963 The Health Professions Educational Assistance Act (P.L. 88-129) aided training of physicians, dentists and other public health personnel.
- 1964 Prescription drug expense benefits were introduced.
- 1964 The Nurse Training Act (P.L. 88-581) provided special Federal effort for training professional nursing personnel.
- 1965 Social Security Amendments of 1965 (P.L. 89-97) established a Social Security hospital insurance program for the aged and voluntary supplementary medical insurance program (Medicare) and grants to states for medical assistance programs (Medicaid).
- 1966 Program of governmental health insurance, Medicare, for people aged 65 and over, became effective July 1.
- 1967 The Age Discrimination in Employment Act (ADEA) became effective.
- The Act applied only to employees between the ages of 40 and 65, and the vast majority of employee benefit plans provided them with the same benefits as younger employees.
 - The Act contained a specific provision (Section 4(f)(2)) which stated that it was permis-

- sible for an employer to observe the terms of any bona fide employee benefit plan such as a retirement, pension or insurance plan which was not a subterfuge to evade the purposes of the Act.
- 1971 The Insurance Medical Scientist Scholarship Fund was formed by several insurance companies, providing full scholarships for students planning careers in medical research and teaching.
- 1972 Social Security Amendments of 1972 (P.L. 92-603) extended health insurance benefits (Medicare) to the disabled and to end-stage renal disease patients; established Professional Standards Review Organization (PSRO) programs; expanded research and demonstrations of financing mechanisms; and introduced automatic cost of living adjustments to disability benefits.
- 1972 Legislation created the Supplemental Security Income program, which federalized categorical public assistance for the aged, blind, and permanently and totally disabled.
- 1973 The Health Maintenance Organization Act (P.L. 93-222) assisted in the establishment and expansion of HMOs.
- 1974 Employee Retirement Income Security Act (ERISA) of 1974 signed into law. While generally thought of as a law that regulates private pension plans, the Act also contains provisions relating to other employee benefit plans that have encouraged the growth of self-insurance.
- 1975 The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) authorized major federal reorganization of health planning programs and set up the national designation of local Health Systems Areas and governing agencies.
- 1976 The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) contained provisions requiring medical school students who receive federal scholarship aid to serve a specified period in rural and inner city areas, and required that medical schools with teaching hospitals provide for a greater proportion of medical residencies in primary medicine.
- 1976 The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) relaxed requirements for HMOs to qualify for federal support.
- 1976 The National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317) set forth national goals for health information and promotion and a systematic strategy for their achievement, stressing health education.
- 1977 The Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) amended the Social Security Act to require uniform reporting of financial data by providers; upgraded criminal penalties for fraud under Medicare-Medicaid programs; and amended certain

- Professional Standards Review Organization (PSRO) provisions.
- 1978 The Health Maintenance Organization Amendments of 1978 (P.L. 95-559) set forth a three-year extension of the HMO assistance program.
- 1978 Title VII of the Civil Rights Act of 1964 was amended to prohibit sex discrimination on the basis of pregnancy for all employment-related purposes.
- 1978 ADEA of 1967 was amended to raise the mandatory retirement age from 65 to 70. The Act prohibits discrimination concerning benefits to older workers. An employer may coordinate benefits with other programs—e.g., Medicare for employees over age 65—provided that total benefits are equivalent to those offered younger workers.
- 1981 The Omnibus Budget Reconciliation Act mandated significant cuts in federal expenditures for health programs; increased Medicare deductibles; removed limit on number of states that can apply for Medicare and Medicaid cost reimbursement waivers; and directed the Secretary of HHS to develop a model prospective reimbursement methodology for inpatient services under Medicare and Medicaid.
- 1982 Tax Equity and Fiscal Responsibility Act of 1982 provided Medicare recognition for any state hospital cost control system that meets certain federal standards, including equitable treatment of all payors; for employees age 65-69 with employer-sponsored health insurance, made Medicare secondary payor; brought federal employees under Medicare; and made certain changes in the methods of hospital reimbursements under Medicare.
- 1983 In response to the requirement of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, a prospective payment system for hospital care of medicare enrollees was enacted as a component of the Social Security Amendments of 1983.
- 1984 Omnibus Deficit Reduction Act of 1984 (P.L. 98-369) extended Medicare as secondary payer of aged spouses of workers under 65; froze Medicare reimbursement for physician fees; and reduced increases in hospital costs.
- 1984 National Organ Transplant Act of 1984 (P.L. 98-507) established a task force on organ transplantation; authorized grants for organ procurement organizations; and established bone marrow registry demonstration and study.
- 1985 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) required that employer group health plans offer continued coverage to workers and their dependents upon termination of employment, and to workers' spouses and dependents who would lose such coverage due to death of the worker, divorce,

- and Medicare eligibility; made private employer health plans primary to Medicare for active workers and their spouses who also have Medicare coverage; required that third party payers reimburse for certain care rendered in government-run veterans and military hospitals; and established a taskforce to study long-term care insurance policies.
- 1986 Tax Reform Act of 1986 (P.L. 99-514) removed the federal tax exemption for Blue Cross/Blue Shield organizations engaged in providing commercial-type insurance; established uniform nondiscrimination rules for group health insurance plans; and restored a partial, 25% tax deduction for health insurance premiums for self-employed individuals and their employees.
- 1986 Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) made private employer health plans primary to Medicare for beneficiaries eligible by reason of permanent disability in cases where the disabled person is a covered dependent under a working spouses' health plan or if the disabled person returns to active employment; and revised the formula for determining Medicare's Part A deductible.
- 1986 ADEA for 1967 was further amended to prohibit mandating retirement at any age; employer-provided benefits for older workers must be equal to younger workers'.

Glossary

Accident an event or occurrence which is unforeseen and unintended.

Accidental Bodily Injury injury to the body as the result of an accident.

Accumulation Period a specified period of time, such as 90 days, during which the insured person must incur eligible medical expenses at least equal to the deductible amount in order to establish a benefit period under a major medical expense or comprehensive medical expense policy.

Actuary a person professionally trained to apply probability and statistics to the practical problems of insurance and related fields. He/she may specialize in life insurance, health insurance (long-term disability and medical), property and casualty insurance, pension work, government programs or a combination of these. His/her responsibilities include calculation of premiums, policy values, reserves and dividends, preparation of statistical studies and forecasting of financial results. Because of his/her broad training an actuary often has administrative and executive responsibilities.

Administrative Services Only (ASO) Plan an arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

Adverse Selection the tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than do persons with average or better health expectations.

Age Limits stipulated minimum and maximum ages below and above which the company will not accept applications or may not renew policies.

Agent an insurance company representative licensed by the state who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Aggregate Indemnity the maximum dollar amount that may be collected for any disability, period of disability, or under the policy.

Allocated Benefits benefits for which the maximum amount payable for specific services is itemized in the contract.

Amendment a formal document changing the provisions of an insurance policy signed jointly by the insurance company officer and the policyholder or his authorized representative.

Application a signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approval (1) word used in connection with the filing of policy and certificate forms and rates with the state insurance department. (2) a word used in connection with the underwriting process of an insurance company and consists of the acceptance of the risk as set forth in the application as made or modified by the insurer. (3) acceptance of an offer from an applicant or policyholder in the form of a contract for new insurance, reinstatement of a terminated policy, request for a policy loan, etc., by an officer of the company.

Assignment the signed transfer of benefits of a policy by the owner of the policy to a third party.

Association Group a group formed from members of a trade or a professional association for group insurance under one master health insurance contract.

Beneficiary the person designated or provided for by the policy terms to receive the proceeds upon the death of the insured.

Benefits the amount payable by the insurance company to a claimant, assignee, or beneficiary under each coverage.

Binding Receipt a receipt given for a premium payment accompanying the application for insurance. If the policy is approved, this binds the company to make the policy effective from the date of the receipt.

Blanket Contract a contract of health insurance affording benefits, such as accidental death and dismemberment, for all of a class of persons not individually identified. It is used for such groups as athletic teams, campers, travel policy for employees, etc.

Blanket Medical Expense a provision which entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Blue Cross an independent, nonprofit membership corporation providing protection on a service basis against the cost of hospital care in a limited geographical area.

Blue Shield an independent, nonprofit membership corporation providing protection on a service basis against the cost of surgical and medical care in a limited geographical area.

Broker a sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies.

Business Insurance a policy which primarily provides coverage of benefits to a business as contrasted to an individual. It is issued to indemnify a business for the loss of services of a key employee or a partner who becomes disabled.

Certificate of Insurance a statement of coverage issued to an individual insured under a group insurance contract, outlining the insurance benefits and principal provisions applicable to the member.

Claim a demand to the insurer for the payment of benefits under the insurance contract.

Coinurance a policy provision frequently found in major medical insurance, by which both the insured person and the insurer share the covered losses under a policy in a specified ratio, i.e., 80% by the insurer and 20% by the insured.

Comprehensive Major Medical Insurance a policy designed to give the protection offered by both a basic and a major medical health insurance policy. It is characterized by a low deductible amount, a coinsurance feature and high maximum benefits.

Consideration one of the elements for a binding contract. Consideration is acceptance by the insurance company of the payment of the premium and the statement made by the prospective policyholder in the application.

Contributory a group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan. Seventy-five percent of the eligible employees must be insured. (see Noncontributory)

Conversion Privilege a privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits (COB) the specific term used to designate the anti-duplication provision designed by the group health insurance industry through the Health Insurance Association of America (HIAA) to limit benefits for multiple group health insurance in a particular case to 100% of the expenses covered and to designate the order in which the multiple carriers are to pay benefits.

Covered Expenses hospital, medical, and miscellaneous health care expenses incurred by the insured that entitle him to a payment of benefits under a health insurance policy. Found most often in connection with major medical plans, the term defines, by either description, reasonableness, or necessity to specify the type and amount of expense which will be considered in the calculation of benefits.

Deductible the amount of covered charges incurred by the protected person which must be assumed or paid by the insured before benefits by the insurance company become payable. A deductible is most commonly used in major medical policies; however, it may also be incorporated in base plan policies.

Diagnosis-Related Groupings (DRGs) system that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories.

Disability physical or mental handicap resulting from sickness or injury. It may be partial or total. (see Partial Disability; Total Disability)

Disability Income Insurance a form of health insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury or disease.

Dismemberment loss of body members (limbs), or use thereof, or loss of sight due to injury.

Double Indemnity a policy provision usually associated with death, which doubles payment of a designated benefit when certain kinds of accidents occur.

Dread Disease Insurance insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis and spinal meningitis.

Duplication of Benefits overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts of different insurance companies, service organizations, or pre-payment plans; also known as multiple coverage.

Earned Premium that portion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance company is considered to have earned 75% of an annual premium after a period of nine months of an annual term has elapsed.

Effective Date the date on which the insurance under a policy begins.

Eligibility Date the date on which an individual member of a specified group becomes eligible to apply for insurance under the [group life or health] insurance plan.

Eligibility Period a specified length of time, frequently 31 days, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Eligible Employees those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Elimination Period a period of time between the period of disability and the start of disability income insurance benefits, during which no benefits are payable. (see Waiting Period)

Enrollment Card a document signed by an employee as notice of his/her desire to participate in the benefits of a group insurance plan.

Evidence of Insurability any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Experience a term used to describe the relationship, usually expressed as a percent or ratio, of premium to claims for a plan, coverage, or benefits for a stated time period.

Experience Rating the process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Experience Refund a provision in most group policies for the return of premium to the policyholder because of lower than anticipated claims.

Family Expense Policy a policy which insures both the policyholder and his/her immediate dependents (usually spouse and children).

Flat Schedule a type of schedule in group insurance under which everyone is insured for the same benefits regardless of salary, position, or other circumstances.

Franchise Insurance a form of insurance in which individual policies are issued to the employees of a common employer or the members of an association under an arrangement by which the employer or association agrees to collect the premiums and remit them to the insurer.

Fraternal Insurance a cooperative type of insurance provided by social organizations for their members.

Geographic Divisions (in the United States)
NORTHEAST

New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic: New Jersey, New York, Pennsylvania

MIDWEST

East North Central: Illinois, Indiana, Michigan, Ohio, Wisconsin
West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
SOUTH

South Atlantic: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East South Central: Alabama, Kentucky, Mississippi, Tennessee
West South Central: Arkansas, Louisiana, Oklahoma, Texas

WEST

Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific: Alaska, California, Hawaii, Oregon, Washington.

Grace Period a specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Group Contract a contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

Guaranteed Renewable Contract a contract that the insured person or entity has the right to continue in force by the timely payment of premiums for a substantial period of time, during which period the insurer has no right to make unilaterally any change in any provision of the contract, while the contract is in force, other than a change in the premium rate for classes of policyholders.

Health Insurance protection which provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO) an organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Hospice health care facility providing medical care and support services such as counseling to terminally ill persons.

Hospital Expense Insurance health insurance protection against the cost of hospital care resulting from the illness or injury of the insured person.

Hospital Indemnity a form of health insurance which provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The indemnity is payable on an unallocated basis without regard to the actual expense of hospital confinement.

Hospital Medical Insurance a term used to indicate protection which provides benefits for the cost of any or all of the numerous health care services normally covered under various health care plans.

Incontestable Clause an optional clause which may be used in noncancellable or guaranteed renewable health insurance contracts providing that the insurer may not contest the validity of the contract after it has been in force for two (sometimes three) years.

Indemnity benefits paid in a predetermined amount in the event of a covered loss.

Individual Insurance policies which provide protection to the policyholder and/or his/her family. Sometimes called Personal Insurance as distinct from group and blanket insurance.

Injury Independent of All Other Means an injury resulting from an accident, provided that the accident was not caused by an illness.

Insurable Risk the conditions that make a risk insurable are: (a) the peril insured against must produce a definite loss not under the control of the insured, (b) there must be a large number of homogeneous exposures subject to the same perils, (c) the loss must be calculable and the cost of insuring it must be economically feasible, (d) the peril must be unlikely to affect all insureds simultaneously, (e) the loss produced by a risk must be definite and have a potential to be financially serious.

Insurance protection by written contract against the financial hazards (in whole or in part) of the happenings of specified fortuitous events.

Insurance Company any corporation primarily engaged in the business of furnishing insurance protection to the public.

Insuring Clause the clause which sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Integration a coordination of the disability income insurance benefit with other disability income benefits, such as Social Security, through a specific formula to insure reasonable income replacement.

Key-Man or Key-Person Health Insurance an individual or group insurance policy designed to protect a firm against the loss of income resulting from disability of a key employee.

Lapse termination of a policy upon the policyholder's failure to pay the premium within the time required.

Legal Reserve the minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code.

Level Premium a premium which remains unchanged throughout the life of a policy.

Lifetime Disability Benefit a benefit to help replace income lost by an insured person as long as he/she is totally disabled, even for a lifetime.

Limited Policy a contract which covers only certain specified diseases or accidents.

Long-Term Disability Income Insurance insurance issued to an employer (group) or individual to provide a reasonable replacement of a portion of an employee's earned income lost through serious and prolonged illness or injury during the normal work career. (See also Integration)

Major Medical Insurance health insurance to finance the expense of major illness and injury. Characterized by large benefit maximums ranging up to \$250,000 or no limit, the insurance, above an initial deductible, reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs and medicines. The insured person as co-insurer pays the remainder.

Manual Rate the premium rate developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Medicaid state programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare the hospital insurance system and the supplementary medical insurance for the aged created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act.

Minimum Group the least number of employees permitted under a state law to effect a group for insurance purposes; the purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Minimum Premium Plan (MPP) an arrangement under which an insurance carrier will, for a fee, handle the administration of claims and insure against large claims for a self-insured group.

Miscellaneous Expenses expenses in connection with hospital insurance, hospital charges other than room and board, such as X-rays, drugs, laboratory fees and other ancillary charges. (Sometimes referred to as Ancillary Charges.)

Morbidity the incidence and severity of sicknesses and accidents in a well defined class or classes of persons.

Multiple Employer Trust (MET) a legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis.

National Association of Insurance Commissioners (NAIC) the association of insurance commissioners of various states formed to promote national uniformity in the regulation of insurance.

Noncancellable Guaranteed Renewable Policy an individual policy which the insured person has the right to continue in force until a specified age, such as to age 65, by the timely payment of premiums. During this period, the insurer has no right to unilaterally make any changes in any provision of the policy while it is in force.

Noncontributory a term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. One hundred percent of the eligible employees must be insured.

Nondisabling Injury an injury which may require medical care, but does not result in loss of working time or income.

Nonoccupational Policy contract which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Worker's Compensation. Group Accident and Sickness policies are frequently nonoccupational.

Nonparticipating Insurance plan of insurance under which the policyholder is not entitled to share in the dividend distribution of the company.

Nonprofit Insurers persons organized under special state laws to provide hospital, medical or dental insurance on a nonprofit basis. The laws exempt them from certain types of taxes.

Occupational Hazards occupations which expose the insured to greater than normal physical dangers by the very nature of the work in which the insured is engaged, and the varying periods of absence from the occupation, due to the disability, that can be expected.

Optionally Renewable Contract a contract of health insurance in which the insurer reserves the right to terminate the coverage at any anniversary or, in some cases, at any premium due date, but does not have the right to terminate coverage between such dates.

Overhead Insurance a type of short-term disability income contract that reimburses the insured person for specified, fixed, monthly expenses, normal and customary in the operation and conduct of his/her business or office.

Partial Disability the result of an illness or injury which prevents an insured from performing one or more of the functions of his/her regular job.

Participating Insurance insurance issued by an insurance company providing participation in dividend distribution.

Physician's Expense Insurance coverage which provides benefits toward the cost of such services as doctor's fees for nonsurgical care in the hospital, at home or in a physician's office, and X-rays or laboratory tests performed outside the hospital. (Also called Regular Medical Expense Insurance.)

Policy the legal document issued by the company to the policyholder which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

Policy Term that period for which an insurance policy provides coverage.

Pre-Existing Condition a physical and/or mental condition of an insured which first manifested itself prior to the issuance of his/her policy or which existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO) an arrangement whereby a third party payor contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

Premium the periodic payment required to keep a policy in force.

Pre-Paid Group Practice Plan a plan under which specified health services are rendered by participating physicians to an enrolled group of persons, with a fixed periodic payment in advance made by or on behalf of each person or family. If a health insurance carrier is involved, a contract to pay in advance for the full range of health services to which the insured is entitled under the terms of the health insurance contract. Such a plan is one form of Health Maintenance Organization (HMO).

Principal Sum the amount payable in one sum in the event of accidental death and in some cases accidental dismemberment.

Professional Standards Review Organization (PSRO) an organization in which practicing physicians assume responsibility for reviewing the propriety and quality of health care services provided under Medicare and Medicaid.

Proration the adjustment of benefits paid because of a mistake in the amount of the premiums paid or the existence of other insurance covering the same accident or disability.

Qualified Impairment Insurance a form of substandard or special class insurance which restricts benefits for the insured person's particular condition.

Reasonable and Customary Charge a charge for health care, which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recurring Clause a provision in some health insurance policies which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of disability or hospital confinement.

Rehabilitation (1) restoration of a totally disabled person to a meaningful occupation, (2) a provision in some long-term disability policies that provides for continuation of benefits or other financial assistance while a totally disabled insured is retraining or attempting to resume productive employment.

Reinstatement the resumption of coverage under a policy which has lapsed.

Reinsurance the acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Renewal continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Residual Disability Benefits a provision in an insurance policy that provides benefits in proportion to a reduction of earnings as a result of disability, as opposed to the inability to work full-time.

Rider a document which amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage, or in any other way amend the original contract.

Risk any chance of loss.

Self-Administration the procedure where an employer maintains all records regarding the employees covered under a group insurance plan.

Self-Insurance a program for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial carriers.

Senior Citizen Policies contracts insuring persons 65 years of age or over. In most cases these policies supplement the coverage afforded by the government under the Medicare program.

Short-Term Disability Income Insurance the provision to pay benefits to a covered disabled person as long as he/she remains disabled up to a specified period not exceeding two years.

Social Security Freeze a long-term disability policy provision which establishes that the offset from benefits paid by Social Security will not be changed regardless of subsequent changes in the Social Security law.

Special Risk Insurance coverage for risks or hazards of a special or unusual nature.

Standard Insurance insurance written on the basis of regular morbidity underwriting assumption used by an insurance company and issued at normal rates.

Standard Provision those contract provisions generally required by state statutes until superseded by the uniform policy provision.

Standard Risk a person who, according to a company's underwriting standards, is entitled to insurance protection without extra rating or special restrictions.

State Disability Plan a plan for accident and sickness, or disability insurance required by state legislation of those employers doing business in that particular state.

State Insurance Department a department of a state government whose duty is to regulate the business of insurance and give the public information on insurance.

Substandard Insurance insurance issued with an extra premium or special restriction to those persons who do not qualify for insurance at standard rates.

Substandard Risk an individual, who, because of health history or physical limitations, does not measure up to the qualification of a standard risk.

Surgical Expense Insurance health insurance policies which provide benefits towards the physician's or surgeon's operating fees. Benefits may consist of scheduled amounts for each surgical procedure.

Surgical Schedule a list of cash allowances attached to the policy, which are payable for various types of surgery, with a maximum amount based upon the severity of the operation.

Third Party Administration administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Time Limit the period of time during which a notice of claim or proof of loss must be filed.

Total Disability an illness or injury which prevents an insured person from continuously performing every duty pertaining to his/her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

Travel Accident Policy a limited contract covering only accidents while an insured person is traveling, usually on a commercial carrier.

Unallocated Benefit a policy provision providing reimbursement up to a maximum amount for the cost of all extra miscellaneous hospital services, but not specifying how much will be paid for each type of service.

Underwriter the term as generally used applies to either (a) a company which receives the premiums and accepts responsibility for the fulfillment of the policy contract; (b) the company employee who decides whether or not the company should assume a particular risk; (c) the agent who sells the policy.

Underwriting the process by which an insurer determines whether or not and on what basis an application for insurance will be accepted.

Unearned Premium that portion of the paid premium applying to the unexpired portion of the policy term; or that portion of the paid premium for which protection has not been received.

Uninsurable Risk one not acceptable for insurance due to excessive risk.

Waiting Period the length of time an employee must wait from his/her date of employment or application for coverage, to the date his/her insurance is effective. (See Probationary Period.)

Waiver an agreement attached to a policy which exempts from coverage certain disabilities or injuries which are normally covered by the policy.

Waiver of Premium a provision included in some policies which exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract.

Worker's Compensation insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

Written Premiums the entire amount of premiums due in a year for all policies issued by an insurance company.



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